Implementation of the VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorders in Adults

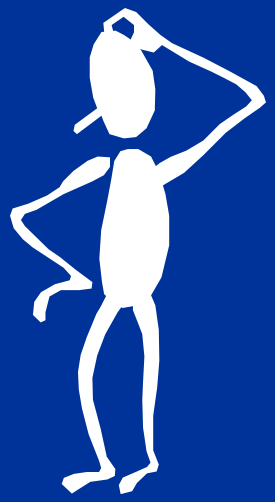
USA MEDCOM

The Wisdom of Pooh

“ Here he is Edward Bear, coming downstairs now, bump, bump, bump, on the back of his head, behind Christopher Robin. It is, as far as he knows, the only way of coming downstairs, but sometimes he feels that there really is another way, if only he could stop bumping for a moment and think of it…”

A. A. Milne

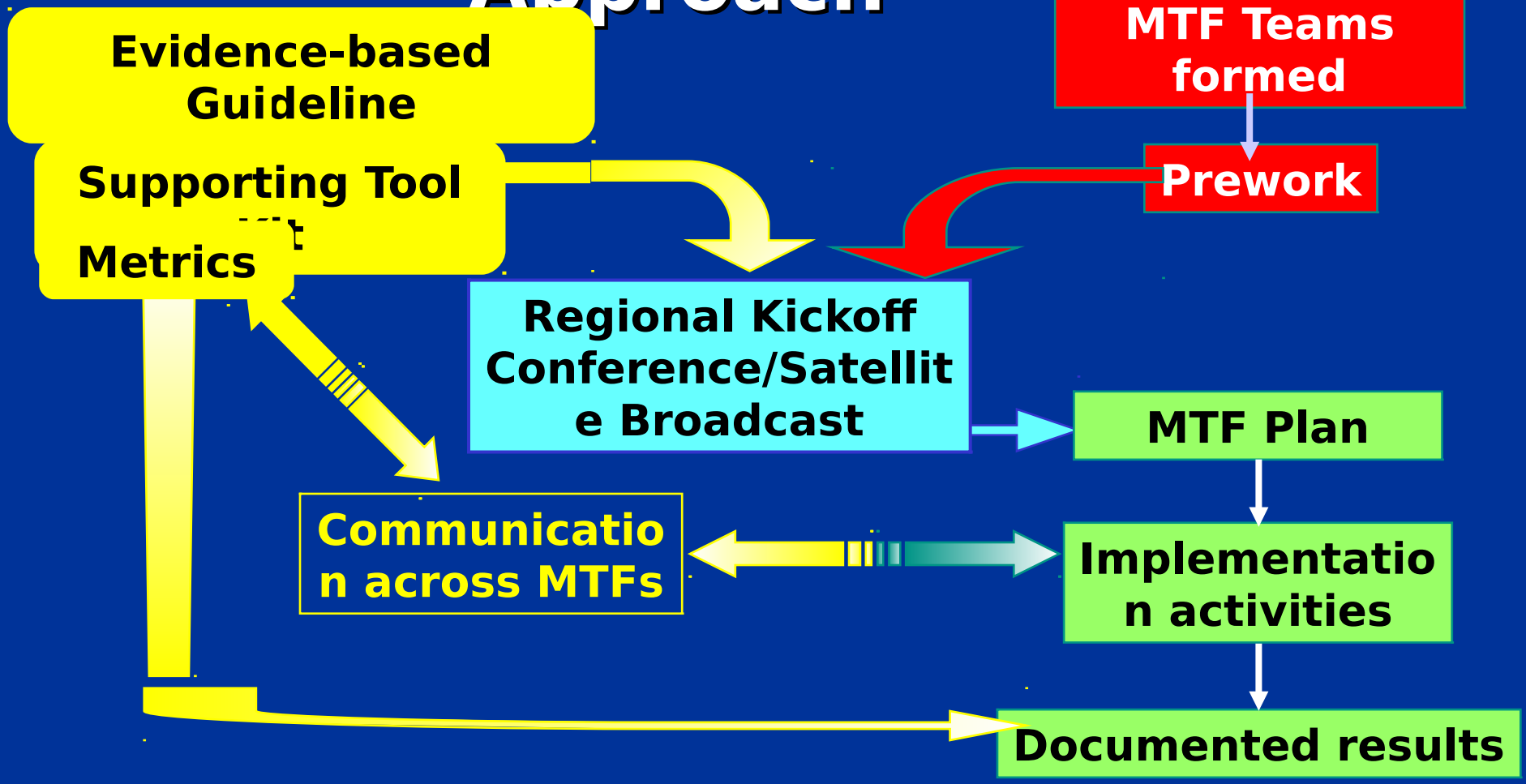
How do we implement the VA/DoD Major Depressive Disorder Guideline?



Clinical Practice Guidelines (CPGs) : Implementation

- **The most challenging step in the guideline process**
- **System process, not provider focused**
- **Team-oriented**

Overview of the Guideline Implementation Approach



Major Depressive Disorder CPG

Team Member Responsibilities:

Systematically Assess and Manage Patient Major Depressive Disorder

- *Be a part of your unit's Major Depressive Disorder Management CPG implementation Team*

Or

- *Provide feedback and suggestions on your unit's Major Depressive Disorder CPG Implementation Plan.*

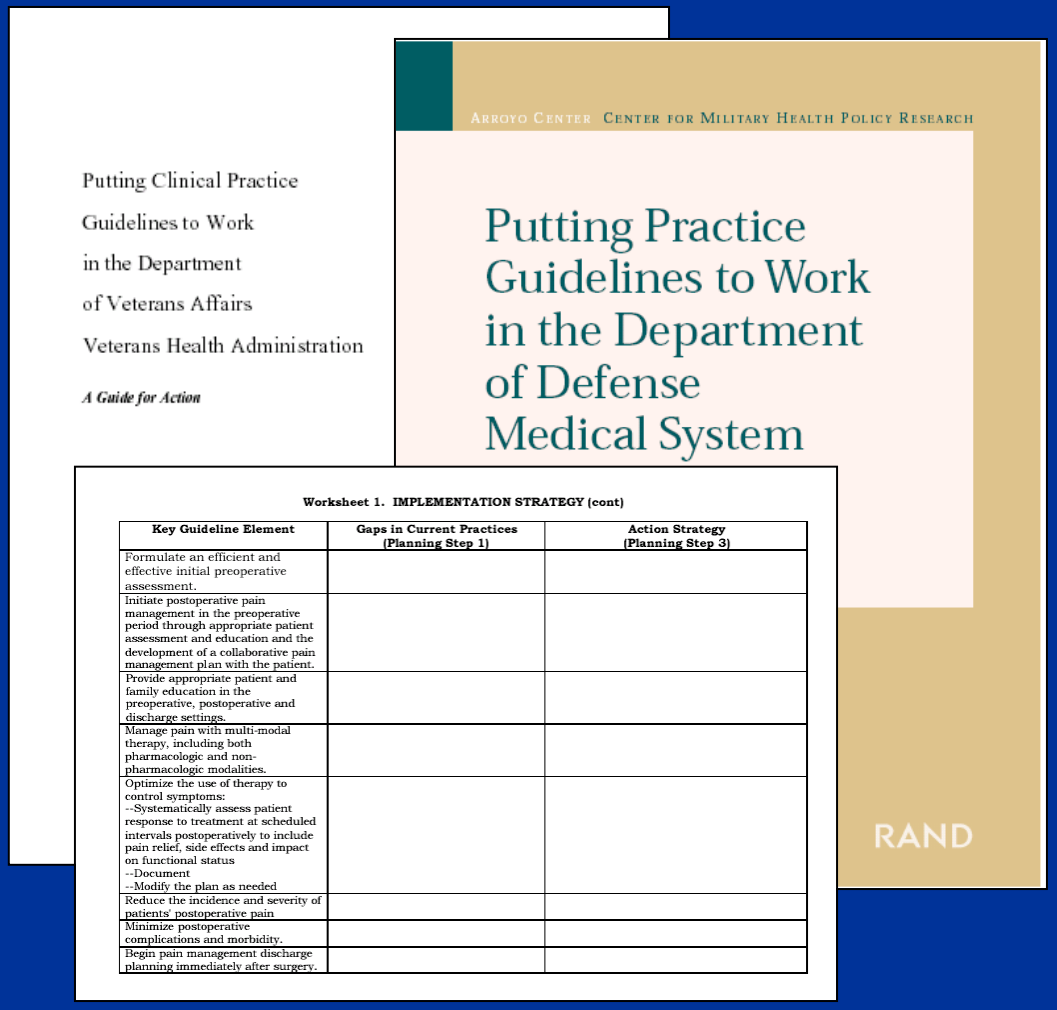
Major Depressive Disorder CPG Team Member Responsibilities:

Be a Part of Your Unit's Major Depressive Disorder Management CPG Team

- **Identify gaps between the guideline and your current practice.**
- **Once a problem has been identified:**
  - Plan your approach to solving the problem
  - Do implement your plan
  - Study your results
  - Act to improve the results or maintain the improvement

Pain CPG Team Member Responsibilities:

Be a Part of Your Clinic's Major Depressive Disorder CPG Team



- **Use the Army / RAND and VA Guideline Implementation Manuals and Team Worksheets (contained in the tool kit binder and downloadable from the Army CPG website) to guide your Major Depressive Disorder Management CPG Implementation Team's efforts.**

Guideline Implementation Checklist

- **Assessment of Level of Effort: Look at Data**
- **Champion Designation**
- **Team Formation**
- **Action Plan Formulation/Implementation**
  - **Clinic Process Changes**
  - **Patient Self-management Education**
  - **Metrics and Monitoring**
    - Rapid-cycle change
  - **Healthcare Team Education**
    - Incorporating Guideline, Clinic Process, Patient Education and Monitoring Information
- **Integration into MTF Processes: Institutionalization**
  - **Education: Orientation, Birth Month, Credentials Clerk**
  - **Monitoring: Peer Review, UM/QM, Executive Committee**

Major Depressive Disorder Guideline

Key Elements

1. **Screen for depression.**
   - **Screening - Routine in primary care ('yes' to either of the following two questions):**
     - **YES/NO During the past month, have you often been bothered by feeling down, depressed, or hopeless?**
     - **YES/NO During the past month, have you often been bothered by little interest or pleasure in doing things?**

Major Depressive Disorder Guideline

Key Elements (Non-inclusive)

2. Identify emergencies:

- **Delirium**
- **Acute or marked psychosis**
- **Severe depression (e.g., catatonia, malnourishment)**
- **Acute danger to self or others**
- **Unstable acute medical conditions**

Major Depressive Disorder Guideline

Key Elements (Non-inclusive)

3. **Assess for "Red Flags".**
   - **High index of suspicion for depression if unexplained symptoms, chronic illness, decreased function, history of abuse or neglect, family history, significant losses, and other psychiatric problems**

Major Depressive Disorder Guideline
Key Elements

4. Conduct depression assessment.

(5 or more of SIG-E-CAPS for at least 2 weeks)

- **(1 or 2 of the 5 symptoms must exist and/or depressed mood):**
  - Sleep (increased or decreased)
  - Interests (decreased)
  - Guilt
  - Energy (decreased)
  - Concentration (decreased)
  - Appetite (increased or decreased)
  - Psychomotor changes (increased or decreased)
  - Suicidal ideas

Major Depressive Disorder Guideline
Key Elements

5. **Identify alternative causes: medical & psychiatric.**
   - **Diseases: any exacerbating depression?**
   - **Substance misuse: any problems present?**
   - **Medications: any depressogenic prescription medications?**

Major Depressive Disorder Guideline
Key Elements

6. **Provide education, discuss options, and jointly choose therapy.**
   - **Educate on depression, treatment options, self-management and possible contributors**
   - **Discuss risks and benefits of psychotherapy, meds, both or neither**
   - **Jointly choose: appropriate treatment is a matter of patient preference**

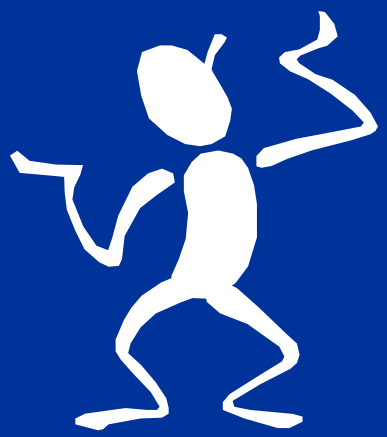
Major Depressive Disorder Guideline

Key Elements

7. **Determine locus of care: Primary care vs. mental health.**

8. **Initiate and monitor the effectiveness of therapy via scheduled reassessment.**
   - **Monitor adherence and side effects every 1-2 weeks: assess response at 4-6 weeks and adjust therapy as indicated; reassess response at 12 weeks**
   - **Consider consultation/referral for an incomplete response**

What can we do to make the VA/DoD Major Depressive Disorder Management Guideline happen in our unit?



Major Depressive Disorder CPG Team Member Responsibilities:

Systematically Assess and Manage Patient's Major Depressive Disorder

1. **Screen for depression.**
   - **Screening - Routine in primary care ('yes' to either of the following two questions)**
     - **YES/NO During the past month, have you often been bothered by feeling down, depressed, or hopeless?**
     - **YES/NO During the past month, have you often been bothered by little interest or pleasure in doing things?**

- **How to implement: Ensure the depression questions are integrated into the routine screening / vital signs process by adding the questions to all Primary Care documentation forms via CHCS form change or stamp.**

Major Depressive Disorder CPG Team Member Responsibilities:

Systematically Assess and Manage Patient's Major Depressive Disorder

- **IF a patient screens positive for Depression**
  - Ensure the positive screen is communicated to the patient's primary care provider
- **The Primary Care Provider will immediately need to:**

2. Identify emergencies:

- **Delirium**
- **Acute or marked psychosis**
- **Severe depression (e.g., catatonia, malnourishment)**
- **Acute danger to self or others**
- **Unstable acute medical conditions**

Major Depressive Disorder CPG Team Member Responsibilities:

Systematically Assess and Manage Patient's Major Depressive Disorder

- **IF after a patient screens positive for depression and NO emergencies are identified, the Primary Care Provider should:**

3. **Assess for "Red Flags" AND**
4. **Conduct depression assessment AND**
5. **Identify alternative causes: medical & psychiatric**

<u>Tools to Assist in Implementation:</u>

- **A standardized depression assessment form has been created to facilitate documentation of depression assessment and management.**

DEPRESSION OUTPATIENT DOCUMENTATION

For use of this form see MEDCOM Circular 40-13

DATE of VISIT: ☐ INITIAL ☐ FOLLOW-UP

SECTION I - VITAL SIGNS / VISIT INFORMATION *(To be Completed by Ancillary Support Staff)*

Reason for Visit to Primary Care Provider: _____

AGE: _____ TEMP: _____ PULSE: _____ RESP: _____ B/P: _____ HT: _____ WT: _____

Do you use tobacco products? ☐ No If yes, what type and how often? _____

Are you interested in quitting? ☐ No ☐ Yes Tobacco cessation literature provided? ☐ Yes ☐ N/A

Are you in pain? ☐ No If yes, severity of pain on a scale of 1-10? _____ Location: _____

Is your visit today deployment related? ☐ Yes ☐ No ☐ Maybe

Allergies _____ _____ *Staff Signature*

SECTION II - DEPRESSION SELF-ASSESSMENT *(To Be Completed by Patient)*

Do you use alcohol? ☐ Yes ☐ No Do you use drugs other than prescribed or over the counter? ☐ Yes ☐ No

List all current medications (amount, dose, how often)? _____

List all herbal remedies or supplements: _____

PRIME-MD PATIENT HEALTH QUESTIONNAIRE:

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

Circle the number that best describes your situation:	Not At All	Several Days	More Than Half the Day	Nearly Every Day
a. Little interest or pleasure in doing things.	0	1	2	3
b. Feeling down, depressed or hopeless.	0	1	2	3
c. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
d. Feeling tired or little energy.	0	1	2	3
e. Poor appetite or overeating.	0	1	2	3
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
g. Trouble concentrating on things, such as reading the newspaper or watching TV.	0	1	2	3
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
i. Thoughts that you may be better off dead or of hurting yourself in some way.	0	1	2	3

2. If you checked off any problems on the questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not Difficult at All ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult

Adapted from PRIME-MD Patient Health Questionnaire (PHQ) ® Trademark of Pfizer Inc

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last first, middle; grade; date; hospital or medical facility)*

_____ *(Patient's Signature)*

PRIME-MD TOTAL SCORE: _____

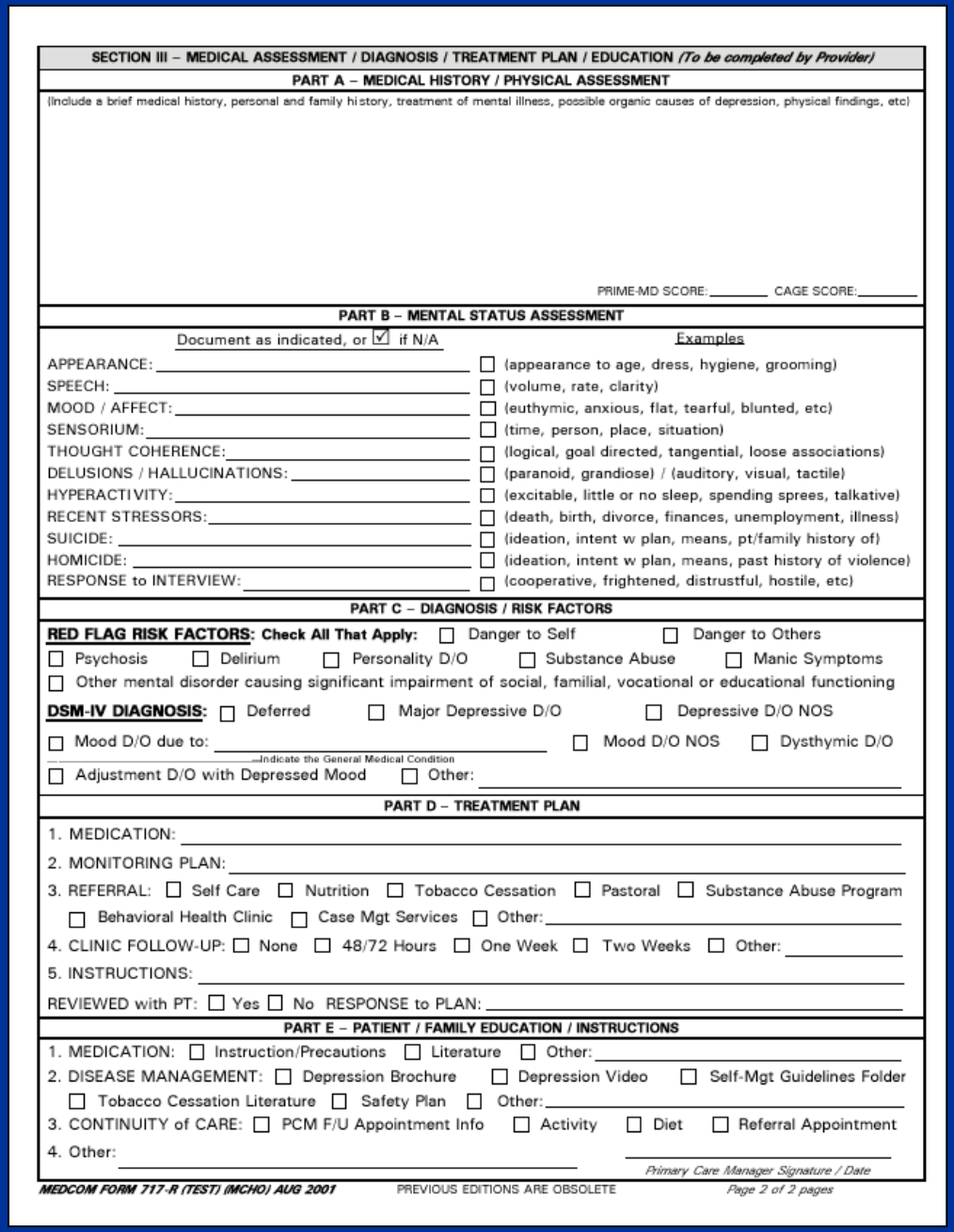
Staff Instructions: Add all numeric responses and place total in the space provided.

MEDCOM FORM 717-R (TEST) (MCHO) AUG 2001 PREVIOUS EDITIONS ARE OBSOLETE *Page 1 of 2 pages* MC V2.00

Provider Documentation Form 717-R

Self-Assessment

1. Meds & OTC
2. Alcohol
3. PRIME-MD PHQ



SECTION III – MEDICAL ASSESSMENT / DIAGNOSIS / TREATMENT PLAN / EDUCATION *(To be completed by Provider)*

PART A – MEDICAL HISTORY / PHYSICAL ASSESSMENT

(Include a brief medical history, personal and family history, treatment of mental illness, possible organic causes of depression, physical findings, etc)

PRIME-MD SCORE:_____ CAGE SCORE:_____

PART B – MENTAL STATUS ASSESSMENT

Document as indicated, or ☑ if N/A	Examples
APPEARANCE:	☐ (appearance to age, dress, hygiene, grooming)
SPEECH:	☐ (volume, rate, clarity)
MOOD / AFFECT:	☐ (euthymic, anxious, flat, tearful, blunted, etc)
SENSORIUM:	☐ (time, person, place, situation)
THOUGHT COHERENCE:	☐ (logical, goal directed, tangential, loose associations)
DELUSIONS / HALLUCINATIONS:	☐ (paranoid, grandiose) / (auditory, visual, tactile)
HYPERACTIVITY:	☐ (excitable, little or no sleep, spending sprees, talkative)
RECENT STRESSORS:	☐ (death, birth, divorce, finances, unemployment, illness)
SUICIDE:	☐ (ideation, intent w plan, means, pt/family history of)
HOMICIDE:	☐ (ideation, intent w plan, means, past history of violence)
RESPONSE to INTERVIEW:	☐ (cooperative, frightened, distrustful, hostile, etc)

PART C – DIAGNOSIS / RISK FACTORS

RED FLAG RISK FACTORS: Check All That Apply: ☐ Danger to Self ☐ Danger to Others

☐ Psychosis ☐ Delirium ☐ Personality D/O ☐ Substance Abuse ☐ Manic Symptoms

☐ Other mental disorder causing significant impairment of social, familial, vocational or educational functioning

DSM-IV DIAGNOSIS: ☐ Deferred ☐ Major Depressive D/O ☐ Depressive D/O NOS

☐ Mood D/O due to: _____ ☐ Mood D/O NOS ☐ Dysthymic D/O

Indicate the General Medical Condition

☐ Adjustment D/O with Depressed Mood ☐ Other: _____

PART D – TREATMENT PLAN

1. MEDICATION: _____
2. MONITORING PLAN: _____
3. REFERRAL: ☐ Self Care ☐ Nutrition ☐ Tobacco Cessation ☐ Pastoral ☐ Substance Abuse Program ☐ Behavioral Health Clinic ☐ Case Mgt Services ☐ Other: _____
4. CLINIC FOLLOW-UP: ☐ None ☐ 48/72 Hours ☐ One Week ☐ Two Weeks ☐ Other: _____
5. INSTRUCTIONS: _____

REVIEWED with PT: ☐ Yes ☐ No RESPONSE to PLAN: _____

PART E – PATIENT / FAMILY EDUCATION / INSTRUCTIONS

1. MEDICATION: ☐ Instruction/Precautions ☐ Literature ☐ Other: _____
2. DISEASE MANAGEMENT: ☐ Depression Brochure ☐ Depression Video ☐ Self-Mgt Guidelines Folder ☐ Tobacco Cessation Literature ☐ Safety Plan ☐ Other: _____
3. CONTINUITY of CARE: ☐ PCM F/U Appointment Info ☐ Activity ☐ Diet ☐ Referral Appointment
4. Other: _____ _____

Primary Care Manager Signature / Date

MEDCOM FORM 717-R (TEST) (MCHO) AUG 2001 PREVIOUS EDITIONS ARE OBSOLETE *Page 2 of 2 pages*

Provider Documentation Form 717-R

Clinician Assessment

1. Medical Hx
2. Structured MS & E
3. Diagnosis
4. "Red Flag" Risk Factors
5. Interdisciplinary Treatment Plan
6. Patient & Family Education/Instructi

Major Depressive Disorder CPG Team Member Responsibilities:

Systematically Assess and Manage Patient's Major Depressive Disorder

- **To facilitate health care team member depression assessment and management, Major Depressive Disorder Provider Reference Cards have also been developed.**
- **The Provider Reference Cards are designed to be placed on metal rings and then hung in each primary care clinic exam room.**
- **Reference cards and metal rings are**

Provider Reminders - Exam Room Cards

VA / DOD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD
DEPRESSION ASSESSMENT and REFERRAL CRITERIA

CARD B 1

GUIDE for INTERPRETING the PRIME-MD PATIENT HEALTH QUESTIONNAIRE SCORES (PHQ - 9)

Major Depressive Syndrome is suggested if:
- Of the 9 items (Item #1, a through i), 5 or more are checked as at least "More Than Half the Days"
- Either item "a" or "b" is positive, that is, at least "More Than half the Days"

Other Depressive Syndrome is suggested if:
- Of the 9 items, "b", "c" or "d" are checked as at least "More Than Half the Days"
- Either item "a" or "b" is positive, that is, at least "More Than half the Days"

PHQ-9 scores can be used to plan and monitor treatment. To score the instrument, tally each response by the number value under the answer headings, (Not At All = 0, Several Days = 1, More Than Half the Days = 2, and Nearly Every Day = 3). Add the numbers together to total the score on the bottom of the questionnaire. Interpret the score by using the guide below:

SCORE:	ACTION:
≤ 4 or	The score suggests the patient may not need depression treatment.
≥ 5 - 14	Provider uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.
≥ 15	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.

The PHQ - 9 also includes a functional health assessment (Item #2). This asks the patient how emotional difficulties or problems impact work, things at home, or relationships with other people.

Patient responses can be one of four: (Not difficult At All, Somewhat Difficult, Very Difficult, and Extremely Difficult). The last two responses suggests that the patient's functionality is impaired. After treatment begins, functional status is again measured to see if the patient is improving.

ASSESSMENT of SUBSTANCE USE DISORDER - "CAGE-" with SCORING

The CAGE is a beneficial mnemonic consisting of questions about alcohol use.

1. Have you ever felt that you should **C**ut down on your drinking?
2. Have people **A**nnoyed you by criticizing your drinking?
3. Have you ever felt bad or **G**uilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (**E**ye-opener)?

Scoring: Item responses on the CAGE are scored 0 to 1, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.

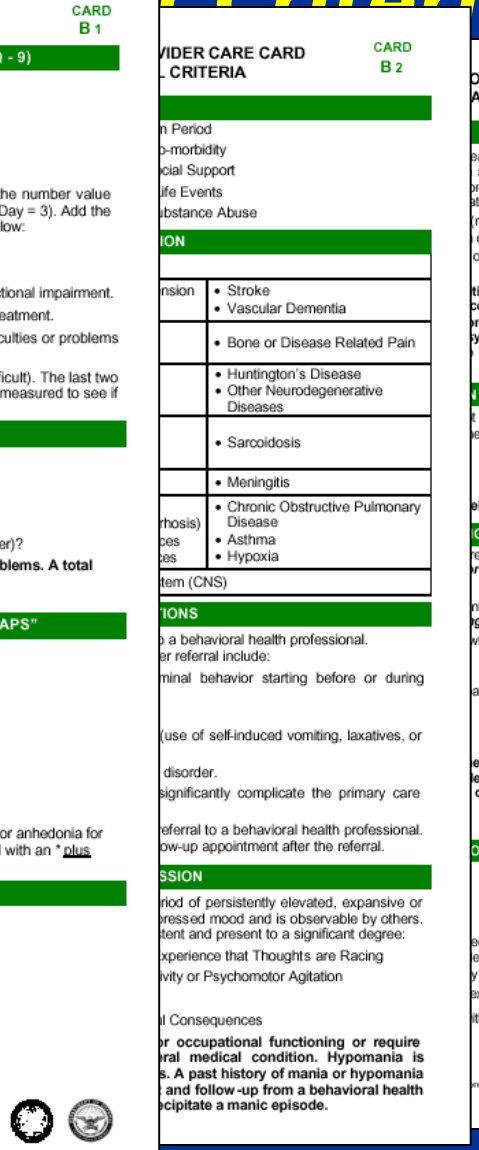
SYMPTOMS of MAJOR DEPRESSIVE DISORDER & DYSTHYMIC DISORDER - "SIG - E - CAPS"

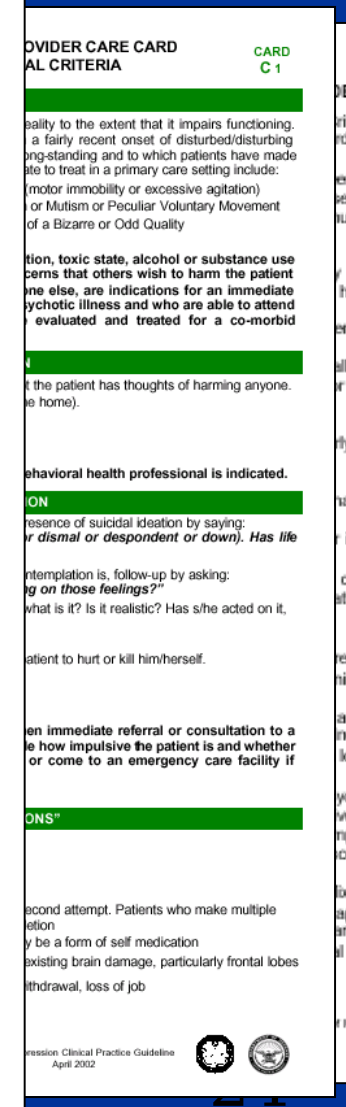
S	**S**leep disorder (either increased or decreased sleep)*
I	**I**nterest deficit (anhedonia)
G	**G**uilt (worthlessness,* hopelessness,* regret)
E	**E**nergy deficit *
C	**C**oncentration deficit *
A	**A**ppetite disorder (either decreased or increased)*
P	**P**sychomotor retardation or agitation
S	**S**uicidality

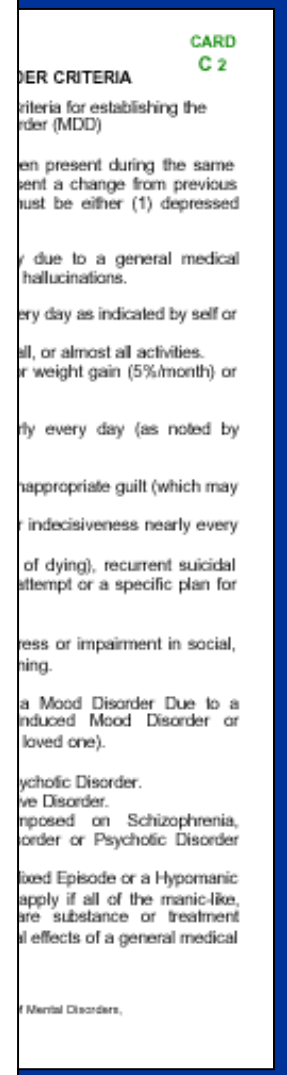
Note: To meet the diagnosis of major depression, a patient must have 4 of the symptoms plus depressed mood or anhedonia for at least 2 weeks. To meet the diagnosis of dysthymic disorder, a patient must have 2 of the 6 symptoms marked with an * plus depressed mood for at least 2 years.

DEPRESSION WARNING SIGNS

- Medically unexplained physical symptoms
- Chronic debilitating medical condition
- Current substance use/abuse
- Decrease in sensory, physical or cognitive function
- Victim of current or past physical or sexual abuse or emotional neglect
- Family history of major depression
- Loss of significant relationship, primary support system or economic status
- Neurological disorder or history of closed head injury
- Protracted care-giving role for a family member with a chronic, disabling condition
- Spousal bereavement and widowhood
- Symptoms or signs of PTSD







Provider Reminders - Exam Room Cards

Antidepressant Medication

[illegible] ANTIDEPRESSANT MEDICATION TABLE

Refer to pharmaceutical manufacturer's literature for full prescribing information

SEROTONIN SELECTIVE REUPTAKE INHIBITORS (SSRIs)

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Citalopram	Celexa	20 mg	60 mg	Reduce dose for the elderly & those with renal or hepatic failure	No serious systemic toxicity even after substantial overdose. Drug interactions may include tricyclic antidepressants, carbamazepine & warfarin.	Nausea, insomnia, sedation, headache, fatigue dizziness, sexual dysfunction anorexia, weight loss, sweating, GI distress, tremor, restlessness, agitation, anxiety.	Response rate = 2 - 4 wks	AM daily dosing. Can be started at an effective dose immediately.
Fluoxetine	Prozac	20 mg	80 mg					
Paroxetine	Paxil	20 mg	50 mg					
Sertraline	Zoloft	50 mg	200 mg					

First Line Antidepressant Medication

Drugs of this class differ substantially in safety, tolerability and simplicity when used in patients on other medications. Can work in TCA nonresponders. Useful in several anxiety disorders. Taper gradually when discontinuing these medications. Fluoxetine has the longer half-life.

SEROTONIN and NOREPHINEPHRINE REUPTAKE INHIBITORS

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Venlafaxine IR	Effexor IR	75 mg	375 mg	Information Not Available	No serious systemic toxicity. Downtaper slowly to prevent clinically significant withdrawal syndrome. Few drug interactions.	Comparable to SSRIs at low dose. Nausea, dry mouth, insomnia, somnolence, dizziness, anxiety, abnormal ejaculation, headache, asthenia, sweating.	Response rate = 2 - 4 wks (4 - 7 days at ~300 mg/day)	BID or TID dosing with IR. Daily dosing with XR. Can be started at an effective dose (75 mg) immediately.
Venlafaxine XR	Effexor XR	75 mg	375 mg					

Dual action drug that predominantly acts like a Serotonin Selective Reuptake inhibitor at low doses and adds the effect of an Norepinephrine Selective Reuptake Inhibitor at high doses. Possible efficacy in cases not responsive to TCAs or SSRIs. Taper dose prior to discontinuation.

SEROTONIN (5-H2A) RECEPTOR ANTAGONIST and WEAK SEROTONIN REUPTAKE INHIBITORS

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Nefazodone	Serzone	200 mg	600 mg	Reduce dose for the elderly & those with renal or hepatic failure	No serious systemic toxicity from OD. Can interact with agents that decrease arousal/impair cognitive performance and interact w ith adrenergic agents that regulate blood pressure.	Somnolence dizziness, fatigue, dry mouth, nausea, headache, constipation, impaired vision. Unlikely to cause sexual dysfunction.	Response rate = 2 - 4 wks	BID dosing. Requires dose titration.
Trazodone	Desyrel	150 mg	600 mg					

Corrects sleep disturbance and reduces anxiety in about one week.

SEROTONIN (5-H2A) and (5-H2C) NOREPINEPHRINE RECEPTOR ANTAGONISTS

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Mirtazapine	Remeron	15 mg	45 mg	Reduce dose for the elderly & those with renal or hepatic failure	Can cause multiple drug interactions; agranulocytosis & neutropenia are considerations.	Main problems are sedation and weight gain.	Response rate = 2 - 4 wks	Can be started at an effective dose immediately.

Difficult to establish an optimal dose. Used infrequently. Reserve for patients unresponsive to other antidepressants due to troubling side effects.

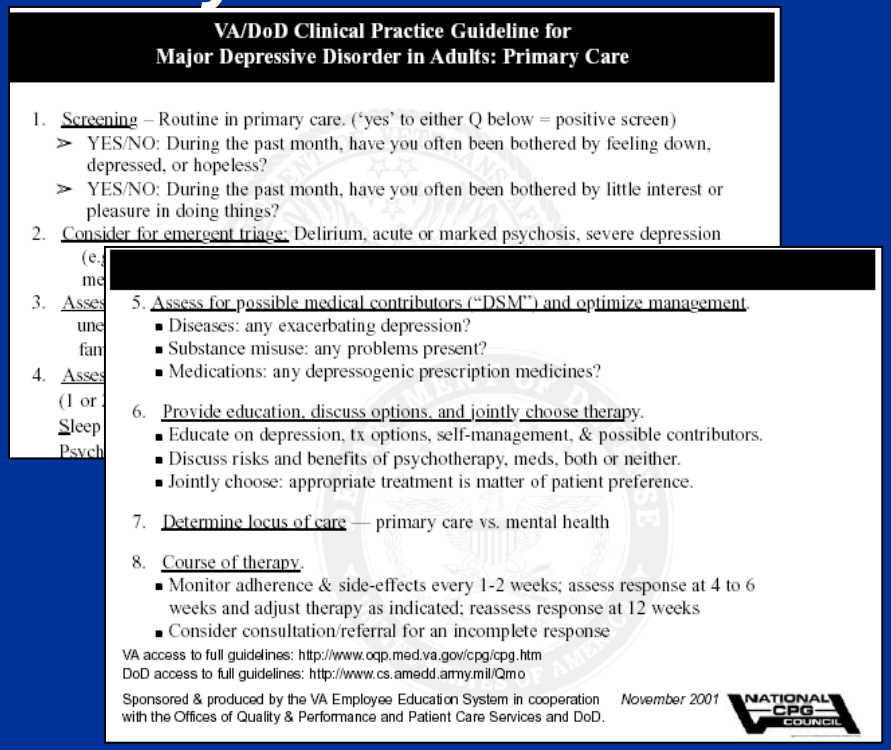
Major Depressive Disorder CPG Team Member Responsibilities:

Systematically Assess and Manage Patient's Major Depressive Disorder

- **Other point-of-care references:**
  - **Provider Pocket Guides**
  - **and Key Element Cards**

Developed to facilitate provider assessment and management of Major Depressive Disorder.

Provider Reminders Key Elements Card



VA/DoD Clinical Practice Guideline for Major Depressive Disorder in Adults: Primary Care

1. Screening – Routine in primary care. ('yes' to either Q below = positive screen)
   - YES/NO: During the past month, have you often been bothered by feeling down, depressed, or hopeless?
   - YES/NO: During the past month, have you often been bothered by little interest or pleasure in doing things?
2. Consider for emergent triage: Delirium, acute or marked psychosis, severe depression
3. Asses
4. Asses

5. Assess for possible medical contributors ("DSM") and optimize management.
   - Diseases: any exacerbating depression?
   - Substance misuse: any problems present?
   - Medications: any depressogenic prescription medicines?
6. Provide education, discuss options, and jointly choose therapy.
   - Educate on depression, tx options, self-management, & possible contributors.
   - Discuss risks and benefits of psychotherapy, meds, both or neither.
   - Jointly choose: appropriate treatment is matter of patient preference.
7. Determine locus of care — primary care vs. mental health
8. Course of therapy.
   - Monitor adherence & side-effects every 1-2 weeks; assess response at 4 to 6 weeks and adjust therapy as indicated; reassess response at 12 weeks
   - Consider consultation/referral for an incomplete response

VA access to full guidelines: http://www.oqp.med.va.gov/cpg/cpg.htm
DoD access to full guidelines: http://www.cs.amedd.army.mil/Qmo

Sponsored & produced by the VA Employee Education System in cooperation with the Offices of Quality & Performance and Patient Care Services and DoD. *November 2001*

Provider Reminders
Primary Care Pocket Guide

Managment of Major Depressive Disorder in Adults

1. Screening – Routine in primary care.
   ('yes' to either Q below = positive screen)
   - ➢ YES/NO: During the past month, have you often been bothered by feeling down, depressed, or hopeless?
   - ➢ YES/NO: During the past month, have you often been bothered by little interest or pleasure in doing things?
2. Consider for emergent triage: Delirium, acute or marked psychosis, severe depression (e.g. catatonia, malnourishment), acute danger to self or others, or unstable acute medical conditions.
3. Assess for "red flags". High index of suspicion for depression if…
   - unexplained symptoms, chronic illness, decreased function, hx of abuse/neglect, family hx, significant losses, other psychiatric problems)
4. Assess for depressive episode.
   4 or more of "sig-e-caps"
   Sleep (↑or↓), Interests (↓), Guilt, Energy (↓), Concentration (↓), Appetite (↑or↓), Psychomotor changes (↑or↓), Suicidal ideas.
5. Assess for possible medical contributors ("DSM") and optimize management.
   - Diseases: any exacerbating depression?
   - Substance misuse: any problems present?
   - Medications: any depressogenic prescription medicines?
6. Provide education, discuss options, and jointly choose therapy.
   - Educate on depression, tx options, self-management, & possible contributors.
   - Discuss risks and benefits of psychotherapy, meds, both or neither.
   - Jointly choose: appropriate treatment is matter of patient preference.
7. Determine locus of care — primary care vs. mental health
8. Course of therapy.
   - Monitor adherence & side-effects every 1-2 weeks; assess response at 4 to 6 weeks and adjust therapy as indicated; reassess response at 12 weeks
   - Consider consultation/referral for an incomplete response

INQUIRING ABOUT SUICIDAL IDEATION

- When a patient describes a depressive episode the Primary Care Provider can empathize and explore for the presence of suicidal ideation by saying:
  "You sound as if you have been feeling pretty miserable (or sad or low or dismal or despondent or down). Has life ever seemed not worth living?"
- If the patient acknowledges suicidal ideation but does not state how active the contemplation is, follow-up by asking:
  "So, you have felt life is not worth living. Have you ever thought about acting on those feelings?"
- If the patient acknowledges that s/he has, explore if the patient has a plan. If so, what is it, is it realistic, has s/he acted on it, if so, how recently?
- If the patient has made a plan, has the means or has recently acted on it, then hospitalization is needed. If the patient is in a gray area, decide how impulsive the patient is and whether a good faith agreement can be made to contact the Provider or come to an emergency care facility if suicidal ideation becomes intrusive, persistent or compelling.

VHA/DoD Clinical Practice Guideline Management of Major Depressive Disorder in Adults Primary Care Pocket Guide

Positive Depression Screen
↓
Emergencies?
↓
Depressive Episode?
↓
Contributing Factors?
("DSM") Disease, Substances, Meds
↓
Optimize Managment of "DSMs"
↓
Provide Education, Discussion Options
↓
Jointly Choose Therapy
↓
Determine Locus of Care
↓
Initiate Therapy
Monitor every 1-2 weeks
↓
Assess Response at 4-6 weeks
Adjust Therapy
↓
Reasses Response at 12 Weeks
↓
Consider Consultation/Referral for Incomplete Response

Sponsored & produced by the VA Employee Education System in cooperation with the Offices of Quality & Performance and Patient Care Services and DoD.
VA access for guidelines: http://www.oqp.med.va.gov/cpg/cpg.asp
DoD access for guidelines: http://www.cs.amedd.army.mil/dCano
August 2001

ANTIDEPRESSANT MEDICATION TABLE

Refer to pharmaceutical manufacturer's literature for full prescribing information

SEROTONIN SELECTIVE REUPTAKE INHIBITORS (SSRIs)

Medical Conditions Related to Depression

Pathology	Disease
Cardiovascular	Coronary artery disease, Congestive heart failure, Uncontrolled hypertension, Anemia, Stroke, Vascular Dementias
Chronic Pain	Fibromyalgia, Reflex sympathetic
Syndrome	dystrophy, Low back pain (LBP), Chronic pelvic pain, Bone or disease related pain
Degenerative	Presbyopia, Presbycusis, Alzheimer's disease, Parkinson's disease, Huntington's disease, Other Neurodegenerative diseases
Immune	HIV (both primary and infection-related), Multiple Sclerosis, Systemic Lupus Erythematosis (SLE), Sarcoidosis
Infection	Systemic Inflammatory Response Syndrome (SIRS), Meningitis
Metabolic/ Endocrine Conditions (include renal and pulmonary)	Malnutrition, Vitamin deficiencies, Hypo/Hyperthyroidism, Addison's Disease, Diabetes Mellitus, Hepatic disease (cirrhosis), Electrolyte disturbances, Acidbase disturbances, Chronic Obstructive Pulmonary Disease (COPD) or Asthma, Hypoxia
Neoplasm	Of any kind, especially pancreatic or central nervous system (CNS)

Medications That Can Cause Depression

Evidence

QE	SR	Drug/Drug Class
I	B	Amphetamine withdrawal, Anabolic Steroids, Digitalis, Glucocorticoids
I	C	Cocaine withdrawal
II-1	C	Reserpine
II-2	A	Gonadotropin-releasing agonists, Pimozide
II-2	B	Propanolol (Beta Blockers)
II-2	C	ACE inhibitors, Antihyperlipidemics, Benzodiazepines, Cimetidine, Ranitidine, Clonidine, Cycloserine, Interferons, Levodopa, Methyldopa, Metoclopramide, Oral contraceptives, Topimmate, Verapamil (Calcium channel Blockers)

Provider Reminders
Specialty Care Pocket Guide

DSM-IV - COMMON MOOD DISORDERS (not inclusive)
DEPRESSIVE DISORDERS

DSM-IV Code	DIAGNOSIS	DESCRIPTION / CRITERIA
		A. Five (or more) of the following symptoms have been present during the same two week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. **Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.** (1) depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others (2) markedly diminished interest or pleasure in all, or almost all activities most of the day, nearly every day, as indicated by either subjective account or observation made by others

General Principles of Pharmacotherapy

- No agent has been proven to be superior to another in efficacy or time to response.
- Use what has worked for the patient in the past.
- The most common cause of treatment failure is an inadequate medication trial.
- If no response at 4-6 weeks, consider switching, combining or augmenting the pharmacotherapy.
- SSRIs are agents of first choice due to ease of use, more tolerable side effects and safety in overdose.
- Counsel pregnant women and those considering pregnancy. The potential risks and benefits of pharmacotherapy must be weighed.

WHAT YOU and YOUR FAMILY SHOULD KNOW ABOUT DEPRESSION

- **What is Major Depression?** - An illness that may be associated with biochemical changes in brain function. More than just a feeling of sadness, it affects day-to-day thoughts, feelings, actions, and physical well-being.
- **Myths** - Major depression is not a trivial disorder, will usually not go away on its own and is not the result of personal weakness, laziness or lack of will power.
- **Incidence** - Depression is a common illness affecting one out of every 20 people sometime in their lifetime.
- **Risk Factors** - Females, people with a first-degree relative with depression, a history of drug or alcohol misuse or a history of anxiety or eating disorders have

nent. People do get

psychotherapy, or a
in primary care or
depending on your

sion are successful-
nerally reserved for

approach is used. A
if the depression is
rk well.

weeks to get the full
t worry it's safe and

problems with your

atment plan. Follow-
s treatment steps or
e taken as directed,

lf. Talk with your
ring treatment.

sion. Discuss these
ible, seek immediate
help you get profes-

atment options. Ask
u may have. Discuss
y patterns, as well as

e antidepressants or
lth.

A.M. (1986).

bereavement
tion.

ANTIDEPRESSANT MEDICATION TABLE

Refer to pharmaceutical manufacturer's literature for full prescribing information

SEROTONIN SELECTIVE REUPTAKE INHIBITORS (SSRIs)

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Citalopram	Celexa	20 mg	60 mg	Reduce dose for the elderly & those with renal or hepatic failure.	No serious systemic toxicity even after substantial overdose. Drug interactions may include tricyclic antidepressants, carbamazepine & warfarin.	Nausea, insomnia, agitation, headache, fatigue dizziness, sexual dysfunction, anorexia, weight loss, sweating, GI distress, tremor, restlessness, agitation, anxiety.	Response rate = 2 - 4 wks	AM daily dosing. Can be started at an effective dose immediately.
Fluoxetine	Prozac	20 mg	80 mg					
Paroxetine	Paxil	20 mg	50 mg					
Sertraline	Zoloft	50 mg	200 mg					

First Line Antidepressant Medication
Drugs of this class differ substantially in safety, tolerability and simplicity when used in patients on other medications. Can work in TCA nonresponders. Useful in several anxiety disorders. Taper gradually when discontinuing these medications. Fluoxetine has the longer half-life.

SEROTONIN and NOREPHINEPHRINE REUPTAKE INHIBITORS (SNRIs)

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Venlafaxine IR	Effexor IR	75 mg	375 mg	Information Not Available	No serious systemic toxicity. Dose taper by patient clinically significant withdrawal syndrome. Few drug interactions.	Comparable to SSRIs at low dose. Nausea, dry mouth, insomnia, somnolence, dizziness, anxiety, abnormal ejaculation, headache, asthenia, sweating.	Response rate = 2 - 4 wks (4 - 7 days at >300 mg/day)	BID or TID dosing with IR. Daily dosing with XR. Can be started at an effective dose immediately.
Venlafaxine XR	Effexor XR	75 mg	375 mg					

Dual action drug that predominantly acts like a Serotonin Selective Reuptake inhibitor at low doses and adds the effect of an Norepinephrine Selective Reuptake Inhibitor at high doses. Possible efficacy in cases not responsive to TCAs or SSRIs. Taper dose prior to discontinuation.

SEROTONIN (5-H2A) RECEPTOR ANTAGONIST and WEAK SEROTONIN REUPTAKE INHIBITORS

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Nefazodone	Serzone	200 mg	600 mg	Reduce dose for the elderly & those with renal or hepatic failure	No serious systemic toxicity from OD. Can interact with agents that decrease neuronal impair cognitive performance. And indirect with adrenergic agents that regulate blood pressure.	Somnolence dizziness, fatigue, dry mouth, nausea, headache, constipation, impaired vision. Unlikely to cause sexual dysfunction.	Response rate = 2 - 4 wks	BID dosing. Requires dose titration. (75 mg) immediately.
Trazodone	Desyrel	150 mg	600 mg					

Corrects sleep disturbance and reduces anxiety in about one week.

DOPAMINE and NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIs)

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Bupropion - IR	Wellbutrin - IR	200 mg	450 mg	Reduce dose for the elderly & those with renal or hepatic failure	Seizure risk at doses higher than max. Drug/drug interactions uncommon.	Rarely causes sexual dysfunction.	Response rate = 2 - 4 wks	BID / TID dosing. Requires dose titration.
Bupropion - SR	Wellbutrin - SR	150 mg	400 mg					

Least likely antidepressant to result in a pt becoming manic. Do not use if there is a history of seizure disorder, head trauma, bulimia or anorexia. Can work in TCA nonresponders.

TRICYCLIC ANTIDEPRESSANTS (TCAs) – Mainly Serotonin Reuptake Inhibitors

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Amitriptyline *	Elavil, Endep *	50 - 100 mg	300 mg	Reduce dose for those with renal or hepatic failure	Serious toxicity can result from OD. Slow system clearance. Can cause multiple drug/drug interactions.	Sedation, increased anticholinergic effects, orthostatic hypotension, cardiac conduction disturbances, arrhythmia & wt gain, dizziness, sexual dysfunction.	Response rate = 2 - 4 wks Therapeutic Levels: Imipramine 200-350 ng/mL	Can be given QD. Monitor serum level after one week of treatment.
Imipramine *	Tofranil *	75 mg	300 mg					
Doxepin *	Sinequan *	75 mg	300 mg					

These antidepressants are not recommended for use in the elderly.
Highest response rates. TATCAs useful in chronic pain, migraine headaches & insomnia.

* Tertiary Amine Tricyclic Antidepressants (TATCAs).

TRICYCLIC ANTIDEPRESSANTS (TCAs) – Mainly Norepinephrine Reuptake Inhibitors

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Desipramine *	Norpramin *	75 - 200 mg	300 mg	Reduce dose for the elderly & those with renal or hepatic failure	Serious toxicity can result from OD. Reserve Maprotiline as a second-line agent due to risk of seizures at therapeutic & nontherapeutic doses.	Generally Good	Response rate = 2 - 4 wks Therapeutic Levels: Desipramine 125-300 ng/mL. Nortriptyline 50-150 ng/mL.	Can be given QD. Can start effective dose immediately. Monitor serum level after one week of treatment.
Nortriptyline	Aventyl/Pamelor	50 mg	150 mg					

Consider Desipramine or Nortriptyline first in the elderly if TCAs are necessary.

* Secondary Amine Tricyclic Antidepressants (SATCAs)

VHA/DoD Clinical Practice Guideline Management of Major Depressive Disorder (MDD) in Adults in the Outpatient Mental Health Specialty Setting

Evaluate for serious immediate needs
Dangerousness, unsafe living situation, substance abuse, psychosis, untreated medical condition - handle as needed before continuing MDD assessment and treatment

↓

Assess for MDD
Use DSM-IV criteria for diagnosis; include other testing as needed (e.g. Beck Depression Inventory, CES-D)

The following must be present for at least two weeks:

- **Depressed mood most of day, nearly every day** } At least one one must be present
- **Markedly diminished interest or pleasure in activities most of day, nearly every day** }

4 or more must be present:

- Weight loss when not dieting or weight gain or decrease/increase appetite
- Insomnia or hypersomnia
- Psychomotor retardation or agitation
- Fatigue, loss of energy
- Feeling of worthlessness, guilt
- Diminished ability to think or concentrate, indecisiveness
- Recurrent thoughts of death, suicidal ideation, suicidal plan or attempt

Assess current MDD treatment if patient referred from other provider; adherence, response, and side effects

↓

Provide education, discuss treatment options, and jointly choose therapy
Educate patient and, if appropriate, family
Discuss options: Empirically supported psychotherapy; medication; combination

↓

Provide therapy as planned with patient and interdisciplinary team
Evaluate patient response every 1-2 weeks
If no improvement in 6 weeks, reevaluate, considering other MDD treatments and possible undiagnosed comorbid conditions
If improving, continue current treatment up to 12 weeks

↓

Expected remission around 12 weeks after initiation of therapy
If remitted at 12 weeks, institute maintenance plan
If improving, but not remitted, continue therapy with timetable for expected remission
If not improving or not remitted after expected time exceeded, reevaluate, considering other MDD treatments and possible undiagnosed comorbid conditions

Sponsored & produced by the VA Employee Education System in cooperation with the Offices of Quality & Performance and Patient Care Services and DoD.
VA access for guidelines: http://www.oqp.med.va.gov/cpg/cpg.asp
DoD access for guidelines: http://www.cs.amedd.army.mil/tamo
August 2001

ONGOING PATIENT ASSESSMENT AND MONITORING

Symptoms of Major Depressive and Dysthymic D/O — "SIGE CAPS"

- **S** Sleep disorder*
- **I** Interest deficit
- **G** Guilt, worthlessness*, hopelessness* regret
- **E** Energy deficit*; fatigue
- **C** Concentration deficit*
- **A** Appetite disorder* -either increased or decreased
- **P** Psychomotor retardation or agitation
- **S** Suicidality

Note: To meet a diagnosis of major depression, a patient must have 4 of the symptoms plus depressed mood or anhedonia for at least 2 weeks. To meet the diagnosis of dysthymic disorder the patient must have 2 of the 6 symptoms marked with an asterisk (*) plus depressed mood for at least 2 years.

SAD PERSONS: ***Suicide risk factors***

- **S** Sex: Males are more likely to kill themselves than females by more than 3 to 1
- **A** Age: Older greater than younger, especially Caucasian males
- **D** Depression: A depressive episode precedes suicide in up to 70% of cases
- **P** Previous attempts: Most people who die from suicide do so on their first or second attempt. Patients who make multiple (4+) attempts have increased risk for future attempts rather than completion.
- **E** Ethanol use: Patients who abuse substances are at increased risk for suicide completion.
- **R** Rational thinking loss: Profound cognitive slowing, distorted perceptions, psychotic depression, pre-existing brain damage.
- **S** Social Support deficit: May be a result of illness, which can cause social withdrawal, loss of job, loss of relationship, legal difficulties.
- **O** Organized plan: Always inquire about the presence of a suicide plan.
- **N** No spouse: May be a result or cause of a depressive disorder.
- **S** Sickness: Intercurrent medical illness.

MONITORING TOOL SENSITIVE TO WEEKLY CHANGES

Center for Epidemiological Studies - Depression Scale (CES-D)
5-item brief version developed as a screening instrument for patients of all ages and 60 or over:

For each of the following, please indicate how often you felt that way during the past week, using the following ratings (**Total score of 4 or more is a positive depression screen**):

Score for question 1 - 4 only

Rarely or none of the time (less than one day)	0
Some or a little of the time (1 to 2 days)	1
Moderately or much of the time (3 to 4 days)	2
Most or almost all the time (5 to 7 days)	3

Item #	Question	Score
1.	I felt that I could not shake off the blues even with help from my family or friends	0 1 2 3
2.	I felt depressed	0 1 2 3
3.	I felt fearful	0 1 2 3
4.	My sleep was restless	0 1 2 3

Score for question 5 only

Most of the time	0
Moderately or much of the time	1
Some of the time	2
Rarely	3

5.	I felt hopeful about the future.	0 1 2 3

This screening instrument is derived from the CES-D (Lewinsohn, et al., 1997).

Major Depressive Disorder CPG

Team Member Responsibilities:

Systematically Assess and Manage Patient's Major Depressive Disorder

- **IF the primary care provider identifies that patient has a major depressive disorder, the primary care provider should:**

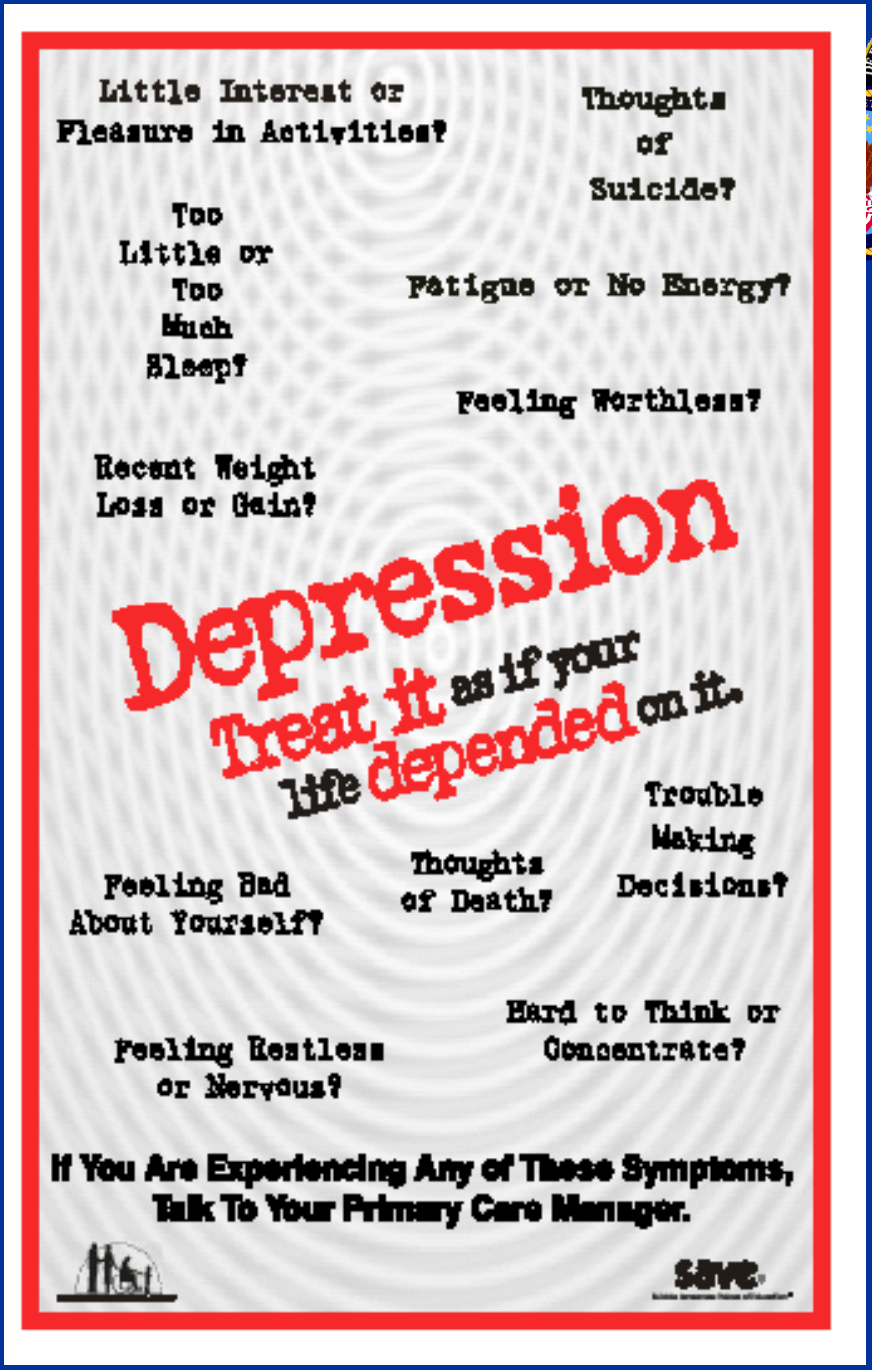
6. Provide education, discuss options, and jointly choose therapy.

<u>Tools to Assist in Pt Education Implementation:</u>

- Patient Education Brochure
- Patient Education Video and CD-ROM
- Patient Action Plan
- Posters

Patient & Family Education Brochure

Available in Spanish

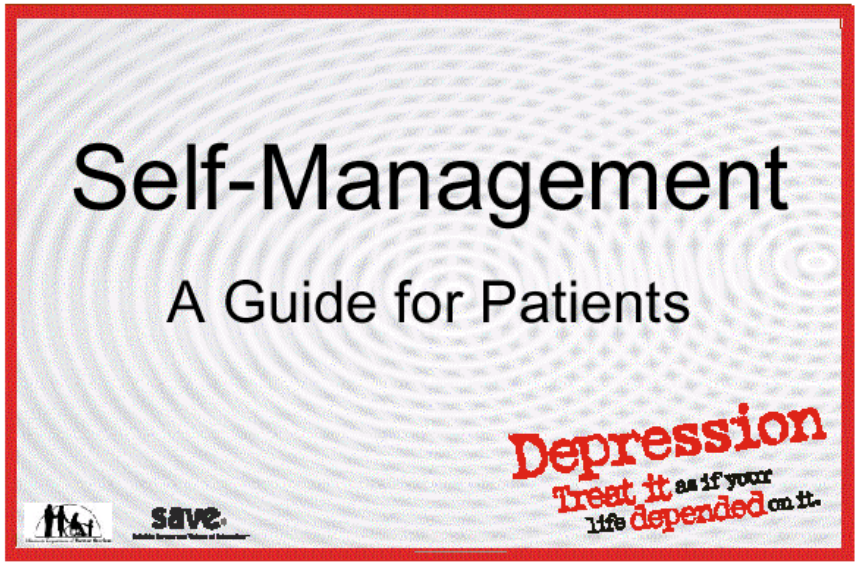


Patient Action Plan

WHAT YOU and YOUR FAMILY SHOULD KNOW ABOUT DEPRESSION

- **What is Major Depression? -** A medical illness, characterized by depression that is believed due to biochemical changes in brain function.
- **Myths -** Major depression is not a trivial disorder, will not go away on its own and is not the result of personal weakness, laziness or lack of will power.
- **Incidence -** Depression is one of the most common illnesses treated by health care professionals, affecting one out of every 20 people sometime in their lifetime.
- **Risk Factors -** Females, people with a first degree relative with depression, people with a history of drug or alcohol abuse or people with a history of anxiety or eating disorders have an increased incidence of depression.
- **Treatment Response -** Depression is very responsive to treatment through antidepressant medication, psychotherapy or a combination. People do get better.
- **Medications -** All antidepressant medications take several weeks to produce their full effect.
- **Medication Safety -** Antidepressants are safe when taken as prescribed and are not addicting.
- **Medication Side Effects -** Discuss medication side effects or other problems with your primary care manager. Most problems can be resolved.
- **Don't -** Drink alcohol, self-medicate, blame yourself or make major life decisions or changes during treatment.
- **Do -** Get plenty of rest, exercise, eat regularly, socialize.
- **Outpatient vs Inpatient Care -** Most depressions are successfully treated in the primary care manager's office. Inpatient hospitalization is generally reserved for patients who have delusions or hallucinations or are a danger to themselves or others.
- **Consultation/Referral -** Sometimes a second opinion is required because a combination of treatments might work best, or the depression is severe or lasts a long time or the first treatment did not work well.
- **Treatment Compliance -** Medication must be taken as directed, including dosage, frequency and length of time prescribed. Follow-up appointments with your primary care manager, mental health specialist or others need to be kept as scheduled.
- **Suicide -** Thoughts of death often accompany depression. Always discuss this symptom with your primary care provider. If your provider is not available, tell a trusted friend or relative who can get you immediate emergency professional help.
- **Communication -** Ask questions about treatment. Verbalize any concerns. Discuss with your primary care manager your feelings, activity, sleep and eating patterns, as well as unusual symptoms or physical problems.
- **Recurrence -** Depression is often recurrent. Maintenance antidepressants are sometimes indicated.

VA/DoD Depression Clinical Practice Guideline
April 2002



Complete a new booklet before each appointment. Review with your Primary Care Manager.

Date/Time of Today's Appointment: _____ Date/Time of Last Appointment: _____

My Primary Care Manager is: _____ at the _____ Clinic

Telephone: _____ Date/Time of Next Appointment: _____

Since my last visit with my Primary Care Manager I have had the following symptoms: (Check all that apply)

☐ Depressed Mood	☐ Feelings of Guilt	☐ Weight Loss	☐ Insomnia
☐ Little Interest/Pleasure	☐ Crying Spells	☐ Weight Gain	☐ Sleeping Too Much
☐ Feelings of Worthlessness	☐ Indecisiveness	☐ Hopelessness	☐ Homicidal Ideation
☐ Fatigue/Loss of Energy	☐ Poor Concentration	☐ Suicidal Ideas	☐ Suicidal Plans

☐ Other Symptoms: _____

Health Care Concerns: I want to discuss the following concerns with my Primary Care Manager:

_____

_____

Medication Information:

My antidepressant medication is: _____ _____ mg, taken at these times: _____

Side Effects I am experiencing are: _____

_____

Other medications I am taking: _____

Educational Resources: I will read or view the following to help me learn more about depression:

☐ CD-ROM "Taking Control of Depression" ☐ VA/DoD Depression Brochure ☐ Other: _____

☐ Medication Information Handout ☐ Depression Video ☐ Other: _____

Referral Services: I will keep the following appointments, if scheduled. Write in appointment date and time.

☐ Behavioral Health: _____ ☐ Chaplain/Minister: _____

☐ Case Management Services: _____ ☐ Substance Abuse Program: _____

Other Referral: _____

Supportive Family or Friends: Fill in Name and Telephone Number:

Name: _____ Phone: _____ Name: _____ Phone: _____

Emergency Contacts: Fill in Telephone Number:

☐ Emergency Dept: _____ ☐ Crisis Center: _____ ☐ Police/EMS: _____

I will contact a support friend or relative or call an emergency contact in the event I experience serious medication side effects, suicidal thoughts or plans or thoughts of harming others.

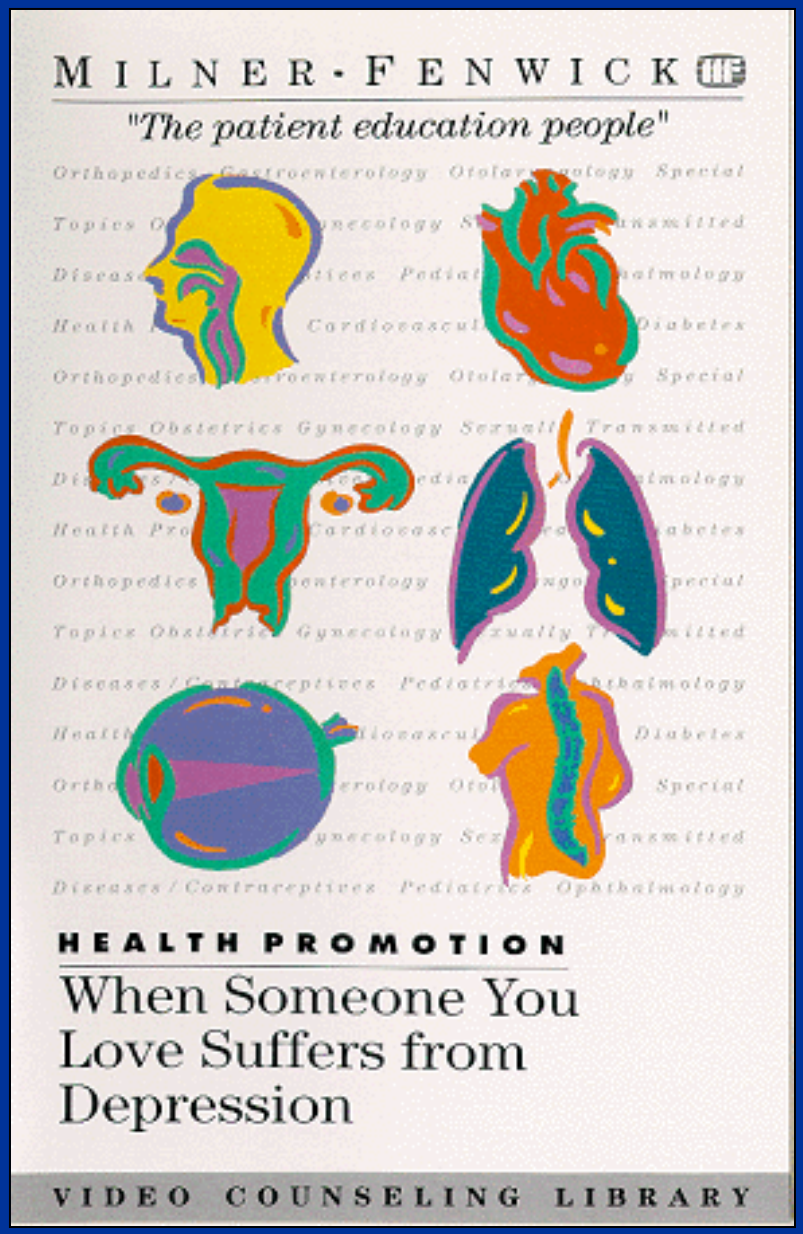
Instructions from My Primary Care Manager:

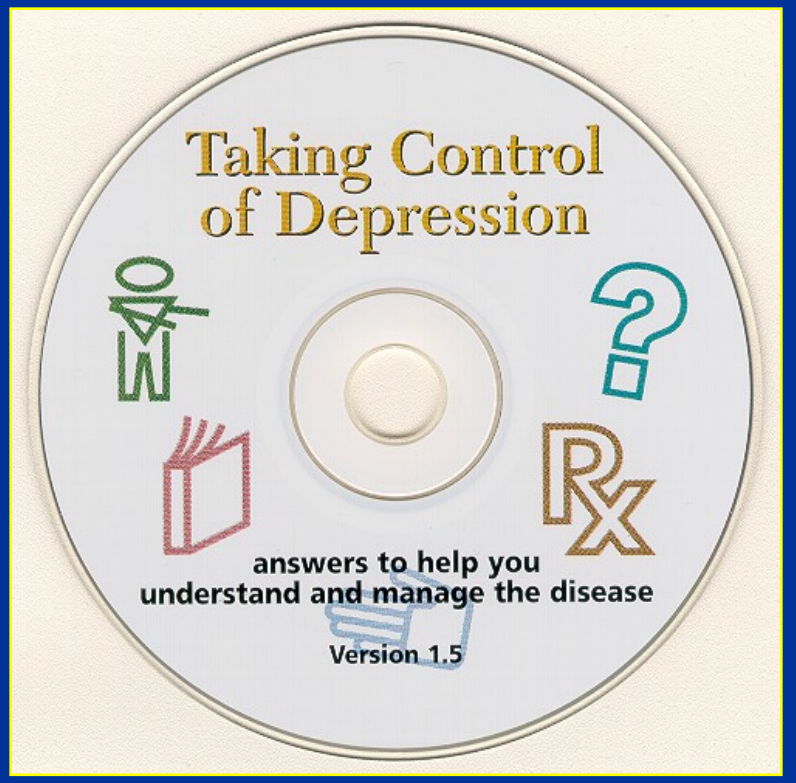
_____

_____

_____
Signature of Patient / Date

Patient Education Video and CD-ROM





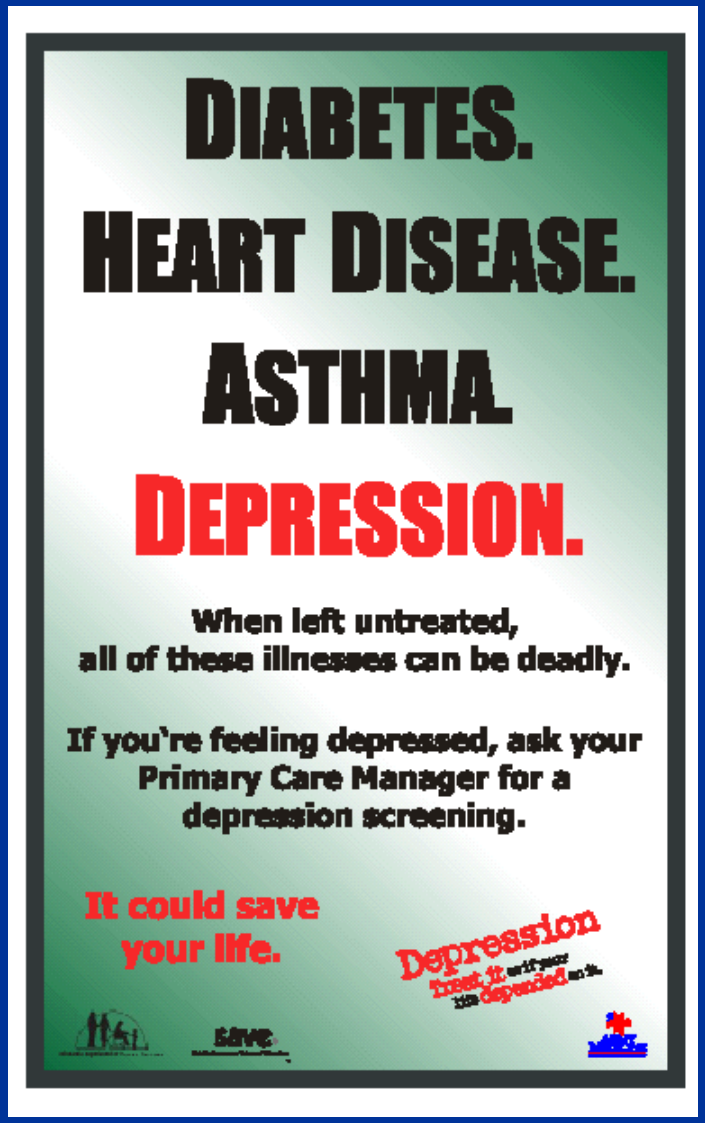
CD-ROM produced by VHA

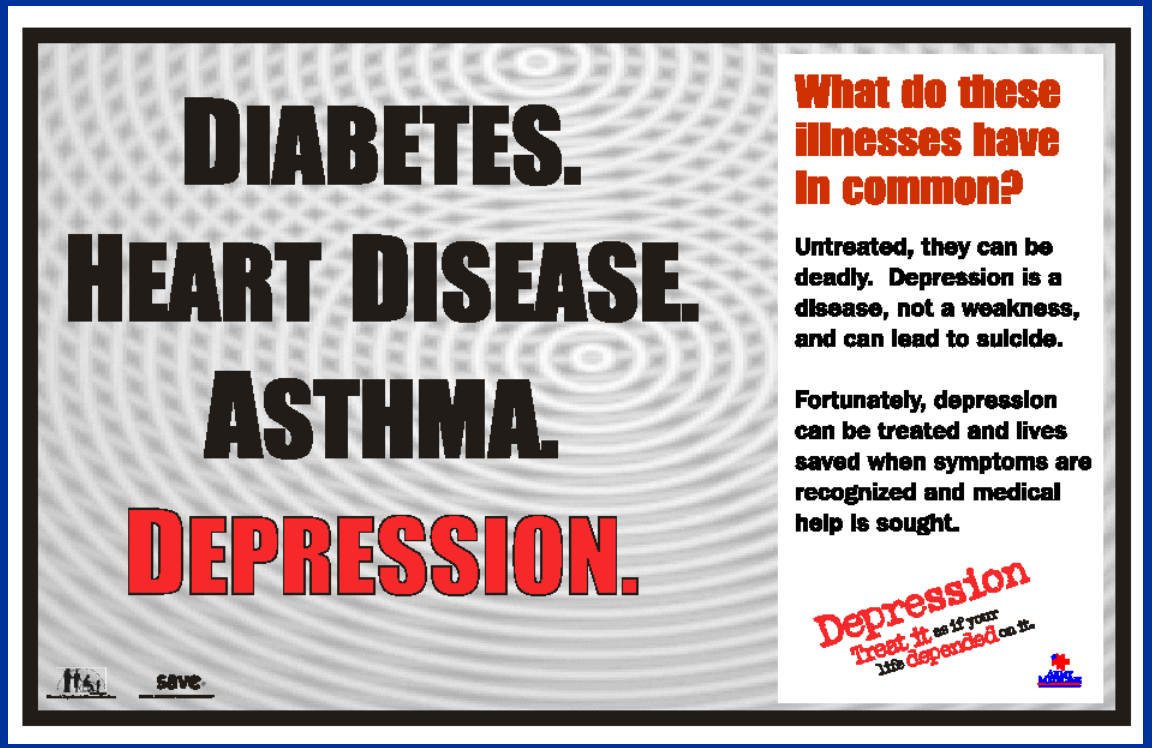
Major Depressive Disorder CPG Team Member Responsibilities:

Systematically Assess and Manage Patient's Major Depressive Disorder

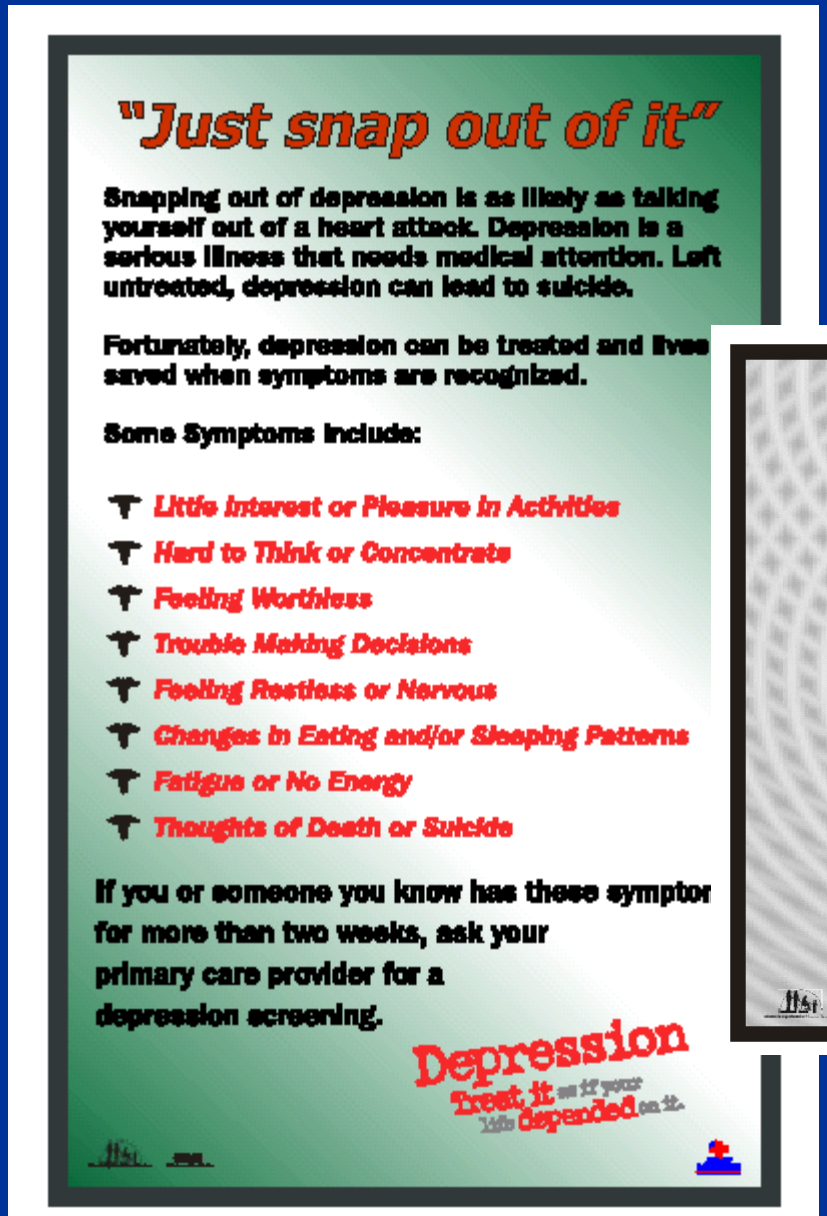
- **To assist in "de-stigmatizing" Major Depressive Disorder for both patients and health care team members, posters have been developed which emphasize that depression is just one of many chronic diseases.**

Patient Posters

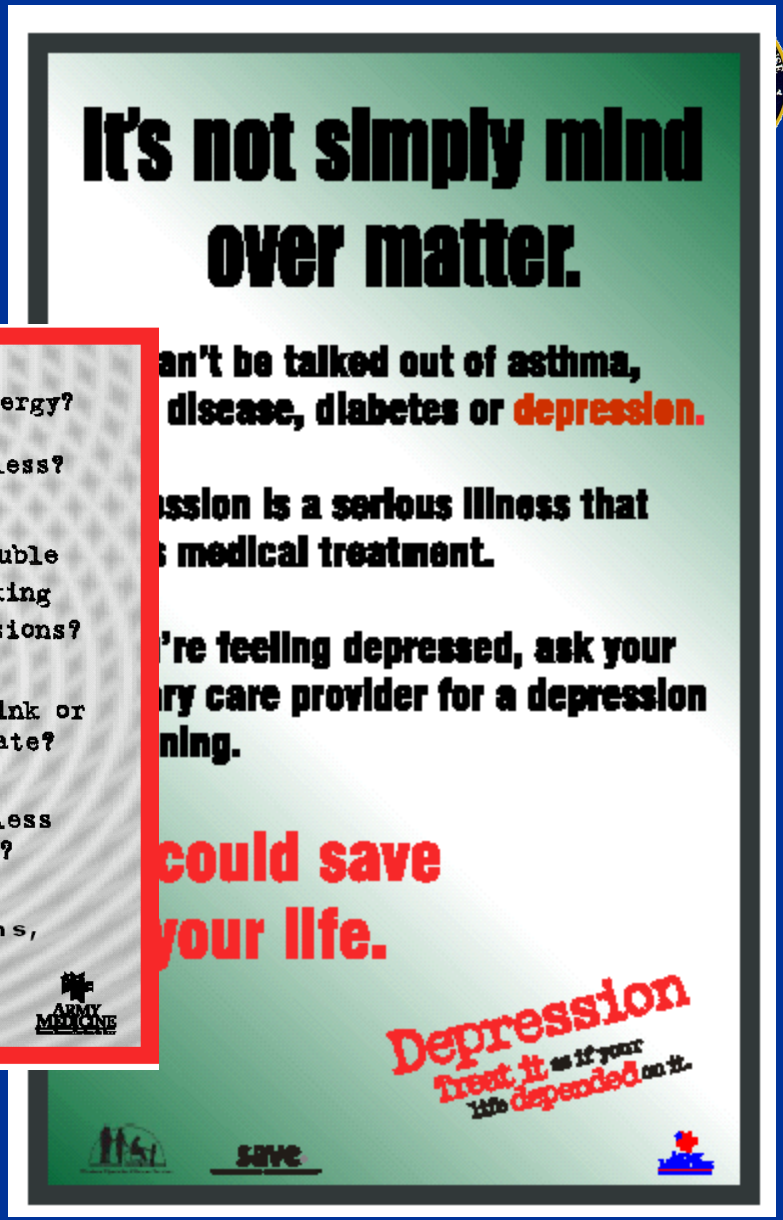




Patient Posters



Patient Posters



Major Depressive Disorder CPG Team Member Responsibilities:

Systematically Assess and Manage Patient's Major Depressive Disorder

- **Once the treatment plan has been decided upon, the primary care provider will:**

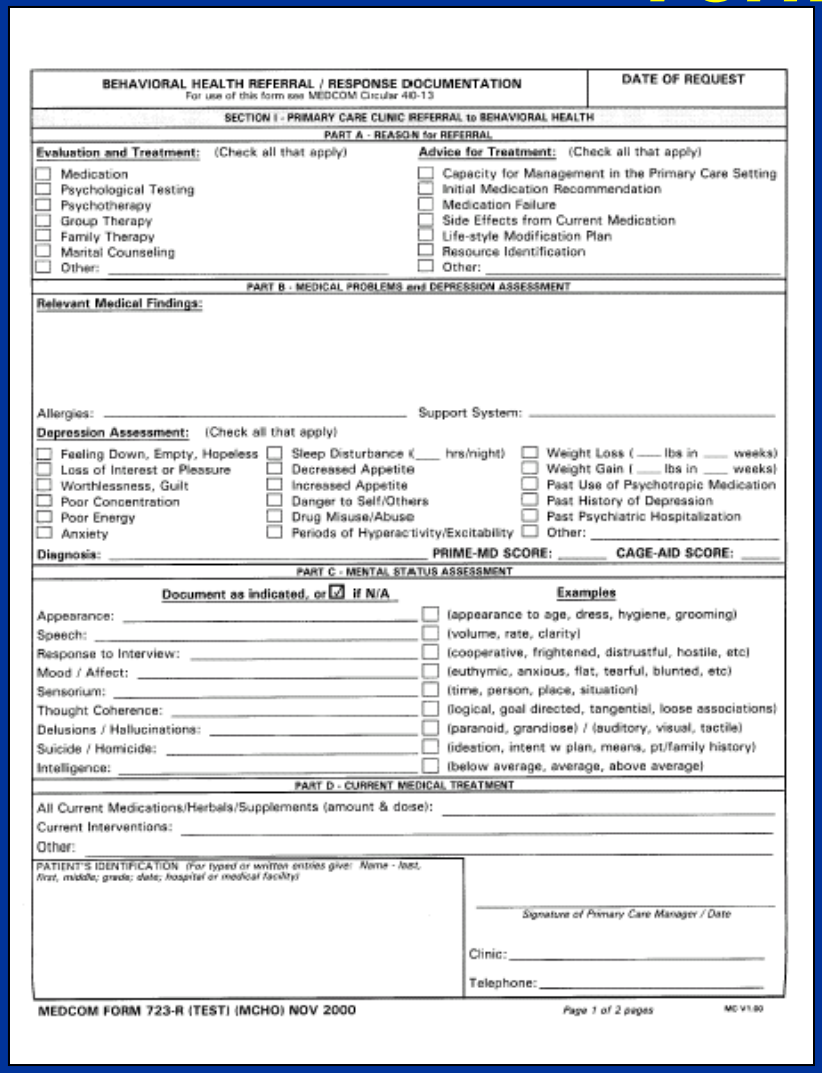
  7. **Determine locus of care: Primary care vs. mental health.**

- **IF it is determined that a patient's needs would be better met in a behavioral health setting, the provider will refer the patient.**

Tool to Assist in Implementation:

A standardized depression referral form has been created to facilitate documentation of depression referral information.

Form 723-R Behavioral Health Referral / Response Documentation Form



BEHAVIORAL HEALTH REFERRAL / RESPONSE DOCUMENTATION
For use of this form see MEDCOM Circular 40-13

DATE OF REQUEST

SECTION I - PRIMARY CARE CLINIC REFERRAL to BEHAVIORAL HEALTH

PART A - REASON for REFERRAL

Evaluation and Treatment: (Check all that apply)

- ☐ Medication
- ☐ Psychological Testing
- ☐ Psychotherapy
- ☐ Group Therapy
- ☐ Family Therapy
- ☐ Marital Counseling
- ☐ Other: _____

Advice for Treatment: (Check all that apply)

- ☐ Capacity for Management in the Primary Care Setting
- ☐ Initial Medication Recommendation
- ☐ Medication Failure
- ☐ Side Effects from Current Medication
- ☐ Life-style Modification Plan
- ☐ Resource Identification
- ☐ Other: _____

PART B - MEDICAL PROBLEMS and DEPRESSION ASSESSMENT

Relevant Medical Findings:

Allergies: _____ Support System: _____

Depression Assessment: (Check all that apply)

- ☐ Feeling Down, Empty, Hopeless
- ☐ Loss of Interest or Pleasure
- ☐ Worthlessness, Guilt
- ☐ Poor Concentration
- ☐ Poor Energy
- ☐ Anxiety
- ☐ Sleep Disturbance (___ hrs/night)
- ☐ Decreased Appetite
- ☐ Increased Appetite
- ☐ Danger to Self/Others
- ☐ Drug Misuse/Abuse
- ☐ Periods of Hyperactivity/Excitability
- ☐ Weight Loss (___ lbs in ___ weeks)
- ☐ Weight Gain (___ lbs in ___ weeks)
- ☐ Past Use of Psychotropic Medication
- ☐ Past History of Depression
- ☐ Past Psychiatric Hospitalization
- ☐ Other: _____

Diagnosis: _____ **PRIME-MD SCORE:** _____ **CAGE-AID SCORE:** _____

PART C - MENTAL STATUS ASSESSMENT

Document as indicated, or ☑ if N/A		Examples
Appearance:	☐	(appearance to age, dress, hygiene, grooming)
Speech:	☐	(volume, rate, clarity)
Response to Interview:	☐	(cooperative, frightened, distrustful, hostile, etc)
Mood / Affect:	☐	(euthymic, anxious, flat, tearful, blunted, etc)
Sensorium:	☐	(time, person, place, situation)
Thought Coherence:	☐	(logical, goal directed, tangential, loose associations)
Delusions / Hallucinations:	☐	(paranoid, grandiose) / (auditory, visual, tactile)
Suicide / Homicide:	☐	(ideation, intent w plan, means, pt/family history)
Intelligence:	☐	(below average, average, above average)

PART D - CURRENT MEDICAL TREATMENT

All Current Medications/Herbals/Supplements (amount & dose): _____

Current Interventions: _____

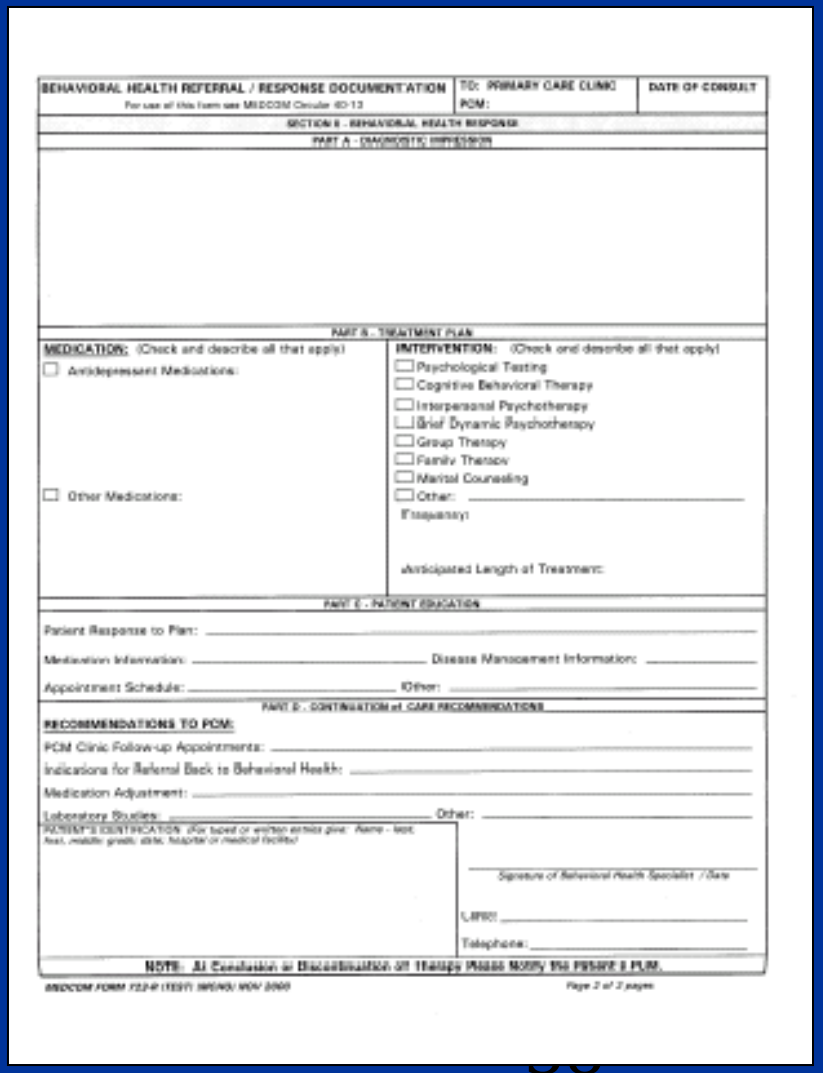
Other: _____

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

_____
Signature of Primary Care Manager / Date

Clinic: _____

Telephone: _____



BEHAVIORAL HEALTH REFERRAL / RESPONSE DOCUMENTATION
For use of this form see MEDCOM Circular 40-13

TO: PRIMARY CARE CLINIC
PCM:

DATE OF CONSULT

SECTION II - BEHAVIORAL HEALTH RESPONSE

PART A - DIAGNOSTIC IMPRESSION

PART B - TREATMENT PLAN

MEDICATION: (Check and describe all that apply)

- ☐ Antidepressant Medications:
- ☐ Other Medications:

INTERVENTION: (Check and describe all that apply)

- ☐ Psychological Testing
- ☐ Cognitive Behavioral Therapy
- ☐ Interpersonal Psychotherapy
- ☐ Brief Dynamic Psychotherapy
- ☐ Group Therapy
- ☐ Family Therapy
- ☐ Marital Counseling
- ☐ Other: _____

Frequency:

Anticipated Length of Treatment:

PART C - PATIENT EDUCATION

Patient Response to Plan: _____

Medication Information: _____ Disease Management Information: _____

Appointment Schedule: _____ Other: _____

PART D - CONTINUATION of CARE RECOMMENDATIONS

RECOMMENDATIONS TO PCM:

PCM Clinic Follow-up Appointments: _____

Indications for Referral Back to Behavioral Health: _____

Medication Adjustment: _____

Laboratory Studies: _____ Other: _____

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

_____
Signature of Behavioral Health Specialist / Date

Clinic: _____

Telephone: _____

NOTE: At Conclusion or Discontinuation of Therapy Please Notify the Primary Care Manager

Major Depressive Disorder: CPG

Team Member Responsibilities:

Systematically Assess and Manage Patient's Major Depressive Disorder

- **Wherever the locus of care the health care team must:**

  8. Initiate and monitor the effectiveness of therapy via scheduled reassessment.

  - Adherence and side effects monitoring every 1-2 weeks
  - Response to therapy assessment at 4-6 weeks and 12 weeks with adjustment of therapy and/or consultation/ referral as needed

  Process Change Needed: Clinics must put in place a systematic process for scheduling of follow-up phone calls and appointments in order to meet this key element.

Major Depressive Disorder CPG Team Member Responsibilities:

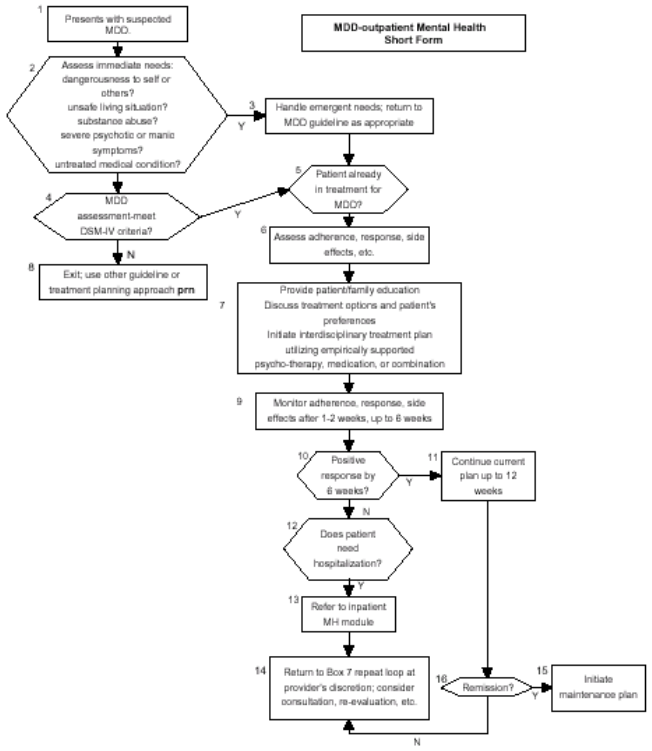
Systematically Assess and Manage Patient's Major Depressive Disorder

- **Health care team education is key to achieving systematic assessment and management of patient Major Depressive Disorder.**
- **Contained in the tool kit are provider educational materials:**
  - Videos
  - Website information
  - Downloadable PowerPoint presentations
  - Text and interactive guideline information

Provider Education Materials
Guideline Summaries: Primary & Specialty Care

VHA/DoD Clinical Practice Guideline
Management of Major Depressive Disorder (MDD) in Adults in Outpatient Mental Health Specialty Setting

Guideline Summary



Sponsored & produced by the VA Employee Education System in cooperation with the Offices of Quality & Performance and Patient Care Services and DoD.

VA access for guidelines: http://www.oqp.med.va.gov/cpg/cpg.asp

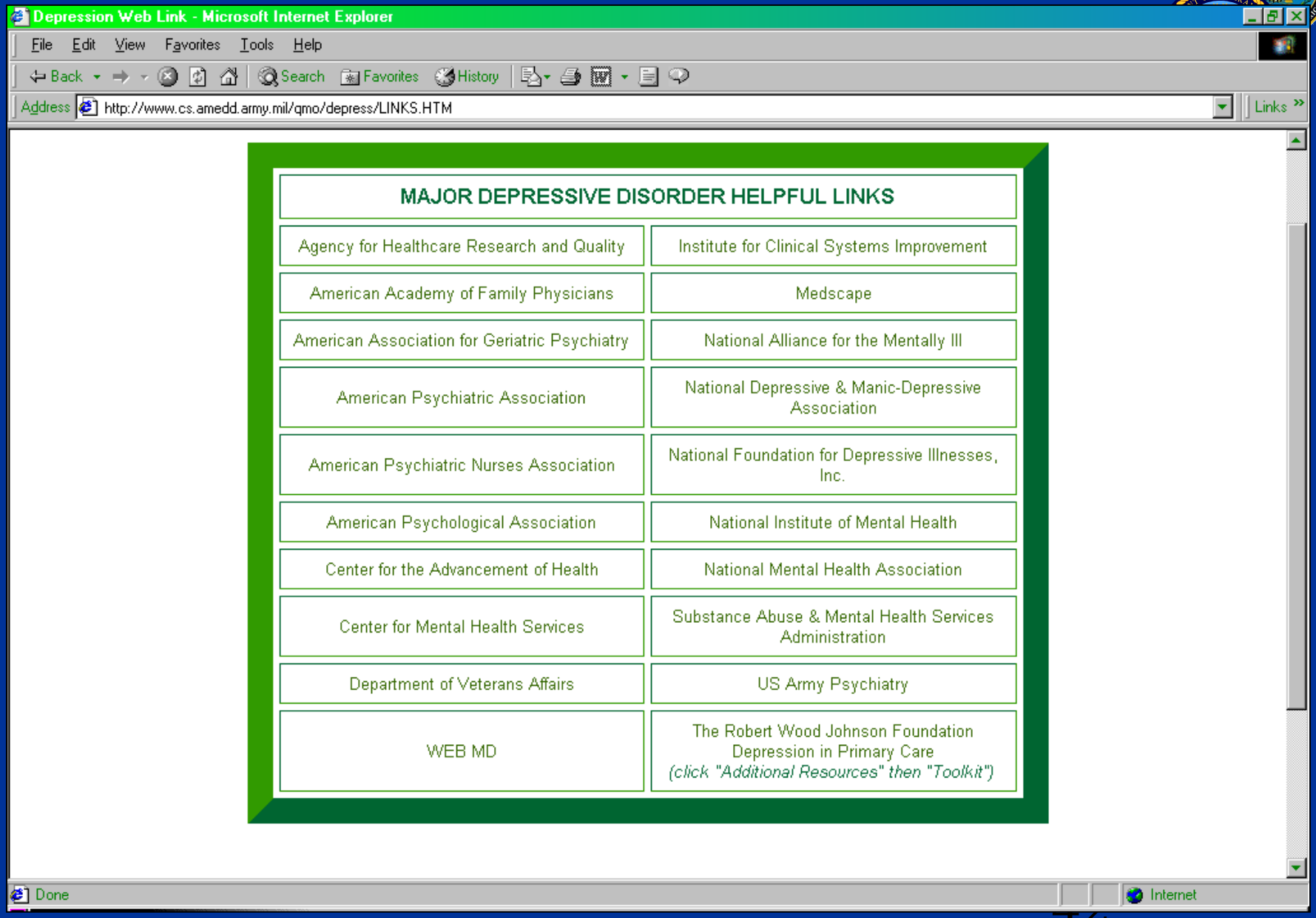
DoD access for guidelines: http://www.cs.amedd.army.mil/Qmo

August 2001

NATIONAL CPG COUNCIL

DSM-IV Code	D
296.2x	Si
296.3x	

Websites



MAJOR DEPRESSIVE DISORDER HELPFUL LINKS

Agency for Healthcare Research and Quality	Institute for Clinical Systems Improvement
American Academy of Family Physicians	Medscape
American Association for Geriatric Psychiatry	National Alliance for the Mentally Ill
American Psychiatric Association	National Depressive & Manic-Depressive Association
American Psychiatric Nurses Association	National Foundation for Depressive Illnesses, Inc.
American Psychological Association	National Institute of Mental Health
Center for the Advancement of Health	National Mental Health Association
Center for Mental Health Services	Substance Abuse & Mental Health Services Administration
Department of Veterans Affairs	US Army Psychiatry
WEB MD	The Robert Wood Johnson Foundation Depression in Primary Care *(click "Additional Resources" then "Toolkit")*

Other Depression Resource Materials

Health Disparities Collaboratives

Changing Practice
Changing Lives

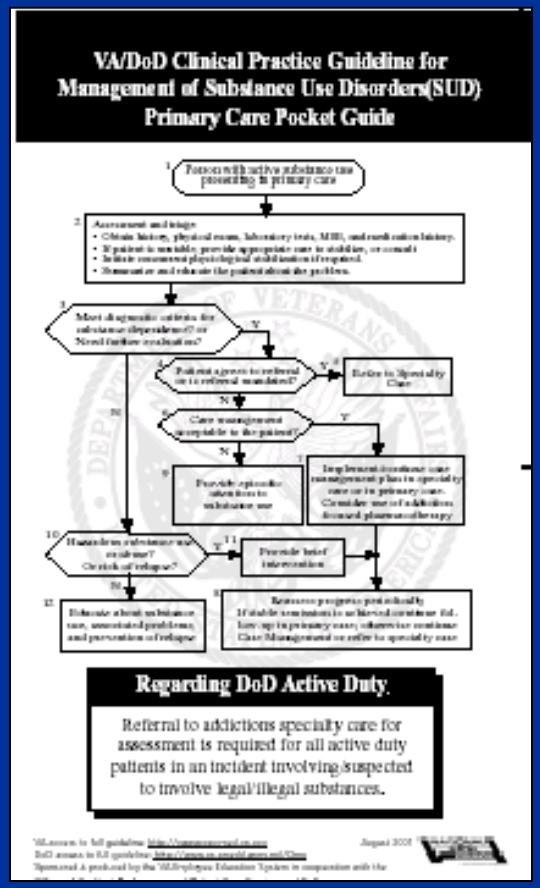
Depression

Major Depressive Disorder CPG Team Member Responsibilities:

Systematically Assess and Manage Patient's Major Depressive Disorder

- **All the Major Depressive Disorder tools are contained in the VA/DoD Behavioral Health Guideline Tool Kit.**
- **Also provided in the Behavioral Health Tool Kit:**
  - VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorder in the Primary Care Setting (SUD Guideline)
  - SUD Guideline Primary Care Pocket Guide
  - SUD Guideline Primary Care Key Elements Card

Substance Use Disorder Tools



VA/DoD Clinical Practice Guideline for Management of Substance Use Disorders(SUD) Primary Care Pocket Guide

1. Person with active substance use presenting in primary care
2. Assessment and triage
   - Obtain history, physical exam, laboratory tests, MSE, and medication history.
   - If patient is unstable, provide appropriate care to stabilize, or consult
   - Initiate concurrent physiological stabilization if required.
   - Summarize and educate the patient about the problem.
3. Select diagnostic criteria for substance dependence(5) or Need further evaluation?
4. Patient agrees to referral or is referral mandated?
5. Refer to Specialty Care
6. Care management acceptable to the patient?
7. Implement treatment care management plan in specialty care or in primary care. Consider use of adjunctive pharmacotherapy
8. Provide episodic attention to substance use
9. Reassess progress periodically. If stable remission is achieved continue Ed., Follow up in primary care, otherwise continue Case Management or refer to specialty care
10. Hazardous substance use or substance dependence? Or risk of relapse?
11. Provide brief intervention
12. Educate about substance use, associated problems, and prevention of relapse

Regarding DoD Active Duty

Referral to addictions specialty care for assessment is required for all active duty patients in an incident involving/suspected to involve legal/illegal substances.

August 2008

Signs and Symptoms of Intoxication and Withdrawal (a)

Types of Intoxication	Signs and Symptoms of Intoxication	Signs and Symptoms of Withdrawal
Alcohol and Sedative-Hypnotics	• Slurred speech • Incoordination • Unsteady gait • Nystagmus • Impairment in attention or memory • Stupor or coma *Note: Highly tolerant individuals may not show signs of intoxication. For example, patients may appear "sober" even at BALs well above the legal limit (e.g., 80 or 100 mg/percent).*	• Autonomic hyperactivity (e.g., diaphoresis, tachycardia, and elevated blood pressure) • Increased hand tremor • Insomnia • Nausea and vomiting • Transient visual, tactile or auditory hallucinations or illusions • Delirium tremens (DTs) • Psychomotor agitation • Anxiety • Irritability • Grand mal seizures
Cocaine or Amphetamine	• Tachycardia or bradycardia • Pupillary dilation • Elevated or lowered blood pressure • Perspiration or chills • Nausea or vomiting • Psychomotor agitation or retardation • Muscular weakness, respiratory depression, or chest pain • Confusion, seizures, dyskinesias, dystonias, or coma	• Dysphoric mood • Fatigue • Vivid, unpleasant dreams • Insomnia or hypersomnia • Increased appetite • Psychomotor retardation or agitation

VA/DoD Clinical Practice Guideline for Management of Substance Use Disorders (SUD) – Primary Care Key Points

Assessment

- Use a standardized alcohol screening procedure (e.g., the CAGE or AUDIT).
- Arrange detoxification or stabilization, if indicated.
- Identify patients with *hazardous substance use* who should receive a brief intervention.
- Identify patients with *substance abuse or dependence* who require a referral to specialty care.

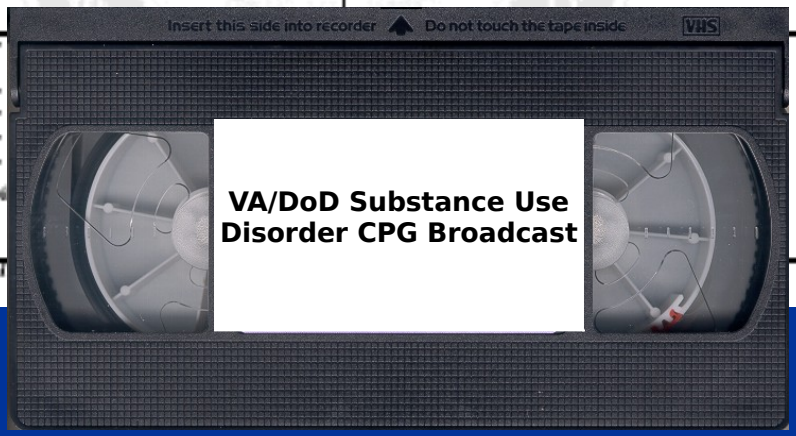
Brief Intervention

- Give feedback about screening results and health risks.
- Inform about safer consumption limits.
- Assess readiness for change.
- Negotiate goals and strategies for change.
- If unsuccessful, consider referral to specialty care.

DoD active duty are required to be referred to specialty care for any incident suspected to involve substance use.

Referral to Specialty Care

- Referral to specialty care is clinically indicated for substance dependence.
- Help overcome barriers to successful referral.



Substance Use Disorder Tools

Provider Reference Card

DSM – IV DIAGNOSTIC CRITERIA for SUBSTANCE DEPENDENCE

DSM-IV defines the diagnostic criteria for substance dependence as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three or more of the following, occurring at any time in the same 12 month period:

1. Tolerance, as defined by either of the following:
   (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
   (b) markedly diminished effect with continued use of the same amount of the substance
2. Withdrawal, as manifested by either of the following:
   (a) the characteristic withdrawal syndrome for the substance
   (b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
3. The substance is often taken in larger amounts or over a longer period than was intended
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use
5. Spending a great deal of time in activities necessary to obtain or use the substance or to recover from its effects
6. Giving up or reducing important social, occupational, or recreational activities because of substance use
7. Continuing the substance use despite the knowledge that it is causing or exacerbating a persistent or recurrent physical or psychological problem

DSM – IV DIAGNOSTIC CRITERIA for SUBSTANCE ABUSE

DSM-IV defines the diagnostic criteria for substance abuse as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12 month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home
2. Recurrent substance use in situations in which it is physically hazardous
3. Recurrent substance-related legal problems
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

ASSESSMENT of SUBSTANCE USE DISORDER - "CAGE"

The Cage-AID is a beneficial mnemonic consisting of questions about alcohol use.

1. Have you ever felt that you should Cut down on your drinking?
2. Have people Annoyed you by criticizing your drinking?
3. Have you ever felt bad or Guilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (Eye-opener)?

Scoring: Item responses on the CAGE are scored 0 to 1, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.

DRUG ABUSE / DEPENDENCE SCREENER

Here is a list of drugs:

- Marijuana, hashish, pot, grass
- Amphetamines, stimulants, uppers, speed
- Tranquilizers, Valium, Librium
- Heroin
- Barbiturates, sedatives, downers, sleeping pills, seconal, quaaludes
- Cocaine, coke, crack
- Opiates, codeine, Demerol, morphine, methadone, Darvon, opium
- Psychedelics, LSD, Mescaline, peyote, psilocybin, DMT, PCP

1. Have you ever used one of these drugs on your own more than 5 times in your life? By "on your own," I mean to get high or without a prescription or more than was prescribed.
   Yes = 1; No = 0 (skip questions 2 and 3)
2. Did you ever find you needed larger amounts of these drugs to get an effect or that you could no longer get high on the amount you used to use?
   Yes = 1, No = 0
3. Did you ever have emotional or psychological problems from using drugs – such as feeling crazy or paranoid or depressed or uninterested in things?
   Yes = 1, No = 0

Consider screen positive for lifetime drug abuse/dependence if item 1 = Yes and either item 2 or 3 = Yes

Source: Rost, Burnam & Smith, 1993

SSMENT of SUBSTANCE USE DISORDER - ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)

ient to circle the answer that is correct for him/her. This test can be administered by interview or self-report.

ften do you have a drink containing alcohol?	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week
any drinks containing alcohol do you have on a typical day when you are drinking?	3 or 4	5 or 6	7 to 9	10 or more
ften do you have six or more drinks on one occasion?	Less than monthly	Monthly	Weekly	Daily or Almost Daily
ften during the last year have you found that you were not able to stop drinking once you had started?	Less than monthly	Monthly	Weekly	Daily or Almost Daily
ften during the last year have you failed to do what was normally expected from you because of drinking?	Less than monthly	Monthly	Weekly	Daily or Almost Daily
ten during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Less than monthly	Monthly	Weekly	Daily or Almost Daily
ten during the last year have you had a feeling of guilt or remorse after drinking?	Less than monthly	Monthly	Weekly	Daily or Almost Daily
ften during the last year have you been unable to remember what happened the night before because you had drinking?	Less than monthly	Monthly	Weekly	Daily or Almost Daily
ou or someone else been injured as a result of your drinking?		Yes, but not in the last year		Yes, during the last year
relative, friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?		Yes, but not in the last year		Yes, during the last year

Questions 1-8 are scored 0, 1, 2, 3, or 4 Questions 9 & 10 are scored 0, 2 and 4 only. The response is as follows

	0	1	2	3	4
1	Never or less	Monthly	2-4 times per month	2-3 times per week	4 or more times per week
2	1 or 2	3 or 4	5 to 6	7 to 9	10 or more
3 - 8	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9 - 10	No		Yes, but not in the last year		Yes, during the last year

um score (for non-drinkers) is 0 and the maximum possible score is 40.
8 or more indicates a strong likelihood of hazardous or harmful alcohol consumption. Source: Babor & Higgins-Biddle, 2001

INTERVIEW APPROACHES BASED on the PATIENT'S READINESS for BEHAVIORAL CHANGE

MPLATION
- oncern about the patient and substance use
- judgmentally that substance abuse is a problem
- a trial of abstinence to clarify the issue
- ringing a family member to an appointment
- e patient's perception of a substance use problem
- e the importance of seeing the patient again

ATION
- ive and negative aspects of substance use
- positive and negative aspects of past periods of e
- e patient's comments on substance use and e
- licit discrepancies between values and action
- a trial of abstinence

ON
- dge the significance of the decision to seek treatment
- elf-efficacy
- patient's ability to successfully seek treatment
- patient decide on appropriate, achievable action
- at the road ahead is tough but very important
- at relapse should not disrupt the patient-clinician ip

ACTION
- Be a source of encouragement and support
- Acknowledge the uncomfortable aspects of withdrawal
- Reinforce the importance of remaining in recovery

MAINTENANCE
- Anticipate difficulties as a means of relapse prevention
- Recognize the patient's struggle
- Support the patient's resolve
- Reiterate that relapse should not disrupt the medical care approach

RELAPSE
- Explore what can be learned from the relapse
- Express concern and even disappointment about relapse
- Emphasize positive aspects of the effort to seek care
- Support the patient's self-efficacy so that recovery seems achievable

Family care providers can provide *brief interaction* during regular office visits. Refer to Specialty Care if the patient needs further evaluation or meets the diagnostic criteria for current substance dependence. DoD active duty are required to be referred to specialty care for any incident suspected to involve substance use. Review/Follow Substance Use Disorder Algorithm Module A for DoD service-specific mandates.

Source: Prochaska & DiClemente, 2001

How can we tell how well our unit/clinic/hospital is doing in implementing the VA/DoD Major Depressive Disorder Guideline?

Team Member Responsibilities:

Know how your clinic/unit/hospital is doing on your Pain CPG Targets

Depression Guideline Quality Targets

- **Detection**
  - % primary care patients screened at each visit for depression (USPSTF)
  - % primary care patients screened annually (VA/DoD)
- **Assessment**
  - % patients diagnosed with a depressive disorder during the previous 12 months (VA/DoD)

Team Member Responsibilities:

Know how your clinic/unit/hospital is doing on your Pain CPG Targets

Depression Guideline Quality Targets

- **Intervention**
  - % of patients newly diagnosed with depression and treated for a major depressive disorder who continue on medications for at least 90 days of the next 120 days or at least 8 psychotherapy visits (VA/DoD)

CPG Team Member Responsibilities:

Know how your clinic/unit/hospital is doing on your Pain CPG Targets

Depression Guideline Quality Targets

- **Effectiveness**
  - % of patients who were seen during the past 12 months with a diagnosis of major depression who have a systematic symptom assessment 12 weeks following diagnosis, or if in remission by week 12, than a systematic symptom assessment is performed at the time of remission (VA/DoD)

Major Depressive Disorder CPG Team Member Responsibilities:

Know how your clinic/unit/hospital is doing on your Pain CPG Targets

- **<u>Conduct chart audits</u> to determine if your clinic is "hitting" your Major Depressive Disorder CPG targets.**

WHO has to do WHAT to make the VA/DoD Major Depressive Disorder Guideline "happen" in our facility?

Primary Care Provider Responsibilities:

Systematically Assess and Manage Patient's Major Depressive Disorder

- **Insert your clinic's health care team member-specific responsibilities here.**

Nursing Responsibilities:

Systematically Assess and Manage Patient's Major Depressive Disorder

- **Insert your clinic's health care team member-specific responsibilities here.**

Tech/Aide Responsibilities:

Systematically Assess and Manage Patient's Major Depressive Disorder

- **Insert your clinic's health care team member-specific responsibilities here.**

Unit/Clinic Management Responsibilities:

Systematically Assess and Manage Patient's Major Depressive Disorder

- **Insert your clinic's health care team member-specific responsibilities here.**

Behavioral Health Physician Responsibilities:

Systematically Assess and Manage Patient's Major Depressive Disorder

- **Insert your behavioral health guideline team member-specific responsibilities here.**

Pharmacy Responsibilities:

Systematically Assess and Manage Patient's Major Depressive Disorder

- **Insert your behavioral health guideline team member-specific responsibilities here.**

Quality Responsibilities:

Systematically Assess and Manage Patient's Major Depressive Disorder

- **Insert your behavioral health guideline team member-specific responsibilities here.**

JCAHO Team Responsibilities:

Systematically Assess and Manage Patient's Major Depressive Disorder

- **Insert your behavioral health guideline team member-specific responsibilities here.**

Leadership Responsibilities:

Systematically Assess and Manage Patient's Major Depressive Disorder

- **Insert your behavioral health guideline team member-specific responsibilities here.**

Where Do I Obtain and Reorder Major Depressive Disorder Tools and Materials?

- **AMEDD web site:**
  - **http://www.cs.amedd.army.mil/Qmo**
  - **Links to VA and AF POC's for tool kit reordering**
- **VA web site for guideline information:**
  - **http://www.oqp.med.va.gov/cpg/cpg.htm**

The Wisdom of Pooh

“ Here he is Edward Bear, coming downstairs now, bump, bump, bump, on the back of his head, behind Christopher Robin. It is, as far as he knows, the only way of coming downstairs, but sometimes he feels that there really is another way, if only he could stop bumping for a moment and think of it…”

A. A. Milne

“Make the BEST way

the EASIEST way

through

TEAM EFFORT”